ALASKA HEALTH CARE COMMISSION

THURSDAY, OCTOBER 2, 2014

8:00 A.M.

DENA'INA CIVIC & CONVENTION CENTER

600 WEST SEVENTH AVENUE

ANCHORAGE, ALASKA

VOLUME 1 OF 2

PAGES 1 THROUGH 266

P R O C E E D I N G S

8:03:32

(On record)

CHAIR HURLBURT: Why don't we go ahead and start? We're still one shy of a quorum of voting members, but we're not going to be voting for a while and I think if you don't start on time, you don't start on time, and it becomes a learning experience.

So I'd like to welcome everybody here that is here. Good morning, Al, and we're just getting started on this. I think, again, we'll have another interesting meeting and have some new folks and we'll give the new folks, in just a few minutes, a chance to introduce yourselves and maybe one or two others will come in.

Larry Stinson is going to be late. He had a meeting over at the University early this morning. He shouldn't be very late, but he should be coming in, and Becky Hultberg is flying up on this morning's flight. Hopefully, it's raining in Juneau, instead of sunny. Again, yesterday, it was sunny and Emily Reiche didn't get up here until almost noon, whereas getting out the night before in the rain, I was golden. It was perfectly on time, but once all that moisture forms and drops and falls out of the sky, it made it easier to fly.

So I usually try to start out, for the new members of the Commission, with just a few thoughts from the news, and the

first one is a challenge for this, and Barb and I can't compete, because we're not coffee drinkers, but I see that a gentleman reported that he has visited more than 11,000 Starbucks in this world. So apparently, this is the new American challenge is how many Starbucks can you visit.

I frequently bring in a book or two to talk about and I won't do it this time. I know Bob is going to mention one that he had recommended that I've read and I see David has read there, but there was another one, and the "Tracking Medicine" is the one that I keep urging everybody to read, but it's a difficult slog that John Wennberg wrote, but the initial person who recommended that was George Rhyneer, who was here yesterday for the meeting with the elders or the over-the-hill gang or whatever we were, on that, and George had recommended the "Tracking Medicine," so when he recommends another one, it's highly credible and I looked up last night, just a little review on it, and as he was pointing out yesterday, what's the big thing -- what are the three top reasons for increases in healthcare costs, and I'm not sure I totally would agree with his response, but it was one of technology, technology, technology, but I think this new book is called "Taming the Beloved Beast" that I've asked Deb to get and I'll read it and maybe at our next meeting, say what I thought about it, but essentially, it is looking at technology and what is done in our system.

So then, we're going to be talking this afternoon some about what is public health and what does it do. Jay Butler will be having a real good presentation on that and I'll share a little bit, but in terms of that, I'll be talking about our public health priorities here that have been pretty consistent, but saw a related news item just today, and this came from the American Society of Clinical Oncology, saying that obesity is about to overtake tobacco as the leading cause of preventable cancer.

It has far overtaken tobacco in terms of the cost of preventable -- of medical services for healthcare needs. Tobacco still kills more people because it's more quickly lethal than obesity is, but it continues to be a problem. Although, we are seeing some reports that maybe we're leveling out in the country, in terms of obesity rates. I hope that's going to be true and we've seen some good things here in Anchorage and Mat-Su that we've talked about.

Two news items that I will -- I want to share, 1) this was a Bloomberg report from earlier this month and the center -- gentleman at the John Mason University in -- outside Washington, they looked at 51 healthcare systems. So these were all countries with a population of at least five million, per capital gross domestic product of at least 5,000, and a life expectancy of at least 70 years, and the United States has improved in ranking.

We have gone from 46 to 44th in terms of that ranking and we're still trying to catch up with countries like Serbia and Turkey and so on, but what they did, they looked at life expectancy. They look at what was spent for healthcare, in terms of dollars or dollar equivalent and percent of GDP.

Singapore was the top ranking and they spend about $2,400 a year, a largely private healthcare system like ours. Whereas, we spend about $9,000, and they live on the average, almost four years longer than we do here.

So the difference, and this has to do with some of the things we've talked about, in looking at it, while they have largely a private healthcare system there, that is what's appropriate for our culture, our way of doing things, what's made us successful as a country, but they do have a lot of cost, more cost-sharing there. So the consumers and users are more engaged and more enlightened buyers there.

So that was kind of interesting, and then, this was an article that warmed my heart because, again, it's what we've talked about and I'll pass this around. It's just front and back, but this was from the -- I'll sorry, Al, from the "Seattle Times" just last week and we have talked about like "Tracking Medicine," the book I just mentioned that John Wennberg wrote, the dramatic differences in the rates of some kinds of elective procedures that you see that don't seem to be real evidence-based, and you know, we talked about a lot of

different things, but basically, in the context that -- to some extent, if you're a provider, if you're a hospital, if you're a doc, you're doing pretty well, and we were created that if you're doing pretty well, it's kind of hard to take initiative to make change, but that is because this whole business of healthcare has the unique ethical and moral dimensions, being totally a business, but having those dimensions, that those who are there where the rubber meets the road, really should be the ones to lead change, and what I liked about this article was that an internist, a primary care internist from Spokane, who's now the President of the Washington State Medical Association, is taking the lead and looking at those kinds of issues, saying for example, "Why is there such a huge difference between CAT scan rates for somebody with abdominal pain if you live in Yakima or if you live in Vancouver, Washington," and there's another example or two.

So this is what, I think, we want to see happening. I think employers and payers, the state of Alaska, the members of the Legislature, when you're faced with the budget and the throughput going down and the price of oil being lower than we built our budget on right now, the financial pressures are huge and the 2.5 billion a year the state pays is there and those folks need to make those decisions, but the leadership for change, I think, will be best coming from those on the

provider side, and not just physicians, not just dentists, but hospital administrators and others, and this was, to me, said I see that kind of thing happening in Washington. So I thought that was good news.

So now, what I'd like to do is maybe ask our new Health Care Commission members, and we have one more coming, who's stuck in traffic right now, who will be coming in.....

MS. ERICKSON: (Indiscernible - too far from microphone).

CHAIR HURLBURT: That's right. She was -- okay, she did. I was thinking this was her first, so.....

MS. ERICKSON: So our two -- our three brand new members are here.

CHAIR HURLBURT: Yeah (affirmative), so if you could introduce yourself, say who you represent, what you do and then a very brief CV on what you do, and Greg, we'll start with you, please.

COMMISSIONER LOUDON: Yeah (affirmative), Greg Loudon, thank you very much, I'm pleased to be here with you guys. I am a principal with Parker, Smith & Feek. It's a commercial insurance brokerage. I represent the insurance seat on the Commission. I've grown in -- or born and raised here in Alaska from Fairbanks, originally. I've been in Anchorage since about 1987, and have been practicing healthcare in Alaska from the payer side for about 20 years.

REPRESENTATIVE HIGGINS: Hi, everybody, I appreciate

being here. I'm from Fairbanks, Alaska. I'm a dentist by trade. I also do a lot of other things, too, but I own two practices. I used to own three, but I sold the one when I got into politics. It just got too much for me, so -- but I Chair the HSS in the House side.

I've been here, like I said, since '67. I think the reason I got involved was because I've seen the way our healthcare was being managed in the state, and you know, I thought, "Well, it's time to get involved in it. I think we can make a difference and we can change things," and that's why, you know, I decided to get into politics and do my part, as far as that goes, so -- but I appreciate it and that's who I am. Thanks.

CHAIR HURLBURT: And Lincoln.

COMMISSIONER BEAN: Good morning. She said to be brief, so I'll just introduce myself in 20 minutes. No, but you know, for us, as Tlingit people, it's really important to always talk to you in our language and (speaking Tlingit language).

Respectful leaders, ladies and gentlemen, thank you for allowing me to sit here and listen to you and learn (speaking Tlingit language) you're honorable people in my language to work for other people. My Tlingit name is (speaking Tlingit language) that means a wolf that cries alone. My actor's name is Lincoln Bean and I'm from Kake. It's really hard for a

tribal leader to be seated here, because we're elected at home and then we're elected to the Health with SEARHC. I represent -- from there, I'm elected to serve with ANTHC. It's all election, almost year-to-year and then we're elected to serve, I serve as Chair for Alaska Native Health Board, and now, I'm here, but I also serve with the VA on that work committee, so I have a little experience on healthcare and it's all my focus and that's what I choose and I enjoy, so thank you for allowing me to be here.

CHAIR HURLBURT: Thank you. Then, I'm just delighted to have all three of you here with us now. You are a great addition and we've all talked that each one represents a constituency. Everybody has represented Alaska well. Lincoln and I have known each other for a long time and as an instigator and an initiator and a leader, he has been very engaged in the transformation of the tribal healthcare system here from the federally governed and operated system, doing a lot of innovative things.

He also Chairs the Alaska Native Health Board now, so has the statewide perspective there and we see things like the Southcentral Clinic here in Anchorage getting international attention for things that they're doing and the VA has contracted with them to provide assistance to them. So that system has provided real leadership in the state.

Representative Higgins, I have so welcomed and enjoyed

the opportunity to work with him as he leads the House HSS Committee there that makes the decisions, as far as the state's role, in a lot of the things that we do and brings the perspective of a provider being there where the rubber meets the road, but then matching that with his responsibilities to the citizens of the state and the tax payers' dollars and so on, and has been a real asset.

Then Greg, we get a little bit of a two-for with Greg because I've known both Greg and his wife, I worked with his wife when she was in a contract over at ANMC back a number of years ago, at the time, that the institution was transitioning over to ANTHC, and in some of the homework, I mention it, because Greg got his wife's -- got Jenny's ideas in it, too, and that helped, but the -- besides being in the business for 20 years and bringing that perspective, representing health insurance and the brokers here, one of the things that really warmed my heart was when Greg was attending one of the meetings that we had here, the Health Care Commission, a couple of years ago, I guess, and we were talking about EOB, explanation of benefits, and when we get one, my wife says, "You take it. That's your business. I can't understand it," but Greg's comment was, "I've been in this business 20 years and I can't understand them," and I have never seen one that I think has been good.

We're working with Jim and folks in the Division of

Retirement and Benefits now and working with Aetna, because they're hard to understand, but it's not that it's an Aetna problem, it's, I find, a universal problem in the healthcare industry.

So Greg has made his money in that business, but his feet are on the ground and he sees the things that aren't good that need to be changed. So now, if we could just go.....

MS. ERICKSON: Should we read the -- while we're welcoming folks, should we read Wes' goodbye?

CHAIR HURLBURT: Yeah (affirmative).

MS. ERICKSON: Do you want me to read it?

CHAIR HURLBURT: Go ahead, sure.

MS. ERICKSON: Okay, since he left us so quickly, and I told him he's not getting off the hook this easily, that we're going to bring him back for a little more formal goodbye when we meet in Juneau sometime this winter, but he really wanted Ward and I to share this message with you, since we didn't know the last meeting was going to be his last meeting.

So to my fellow Commissioners, my decision to step down from the Alaska Health Care Commission is a matter of time management and triage. We have been honored to serve with you on this critically -- I have been honored -- I need to put my reading glasses on, sorry.

I have been honored to serve with you on this critically important commission, but I am on several others, besides more

normal legislative responsibilities. I am proud of what we have accomplished and am confident that Representative Pete Higgins brings healthy new blood at a good time for the Alaska Health Care Commission mission quest to provide a sustainable healthcare plan that honors, protects, and respects all Alaskans.

Thank you for allowing me to work with you. The friendships and the respect I gained for each of you are very important to me. Representative Wes Keller.

I wanted to share that with you at his request.

CHAIR HURLBURT: And yeah (affirmative), I've expressed my appreciation to Wes. Wes really set the bar with the very busy life that our legislators have. He gave a very high priority and remained very engaged and remains an important leader in our state.

If we could just now go around the table and the folks who haven't already introduced themselves, the new members, just say who you are and who you represent, and we'll do that around the table. Susan, you introduced yourself last time with your background, so just say who you are and who you represent.

COMMISSIONER YEAGER: (Indiscernible - too far from microphone).

MS. ERICKSON: Susan, could you turn your mic on, please? Thanks. Just a reminder to everybody, and try to put your

mouth as close as possible, because this is the way the stenographers and also our webinar, folks over webinar pick up.

COMMISSIONER YEAGER: Okay.

MS. ERICKSON: Thanks.

COMMISSIONER YEAGER: Susan Yeager, and I'm the Director of the Alaska Health Care System, representing the federal side.

COMMISSIONER STINSON: Larry Stinson, physician/provider, who just got back from a WAMI meeting this morning.

COMMISSIONER HIPPLER: Allen Hippler, I represent the statewide Chamber of Commerce.

COMMISSIONER ENNIS: Emily Ennis, I'm Executive Director or Fairbanks Resource Agency and I represent the Alaska Mental Health Trust Authority.

MR. PUCKETT: Jim Puckett from Division of Retirement and Benefits, and I'm here on behalf of the Office of the Governor.

COMMISSIONER URATA: Bob Urata, I'm a family physician from Juneau, representing primary care.

SENATOR COGHILL: I'm John Coghill. I'm the state Senate seat.

COMMISSIONER MORGAN: Dave Morgan representing Alaska Community Health Center System.

CHAIR HURLBURT: Thank you all, and then we don't have

any public attendees yet, but Michelle, if you could just introduce yourself?

MS. MAUSHADA: (Indiscernible - too far from microphone).

MS. HEPBURN: (Indiscernible - too far from microphone).

CHAIR HURLBURT: And Craig Holt will be introducing himself a little more later. He will be serving as the very able facilitator and I think you will enjoy that process later on this morning. Barb Hanson is the one who makes everything work and always gets the good food for us. So if you see her -- Deb Erickson, our Executive Director, and if you folks who are critical, could just introduce yourselves?

MR. SAYLOR: (Indiscernible - too far from microphone).

MS. STUDSTILL: (Indiscernible - too far from microphone).

CHAIR HURLBURT: Thank you very much, and again, welcome, to everybody here. So Deb, do you want to say a couple of words before we get into the next section with Craig or just go ahead?

MS. ERICKSON: Well, I -- yeah (affirmative), well, actually, yeah (affirmative), I have a couple of just minor business items that I could go over real quickly and then we could get started with our agenda for today, beyond introductions.

One of those is, you all should have received in the front pouch of your notebook, your pre-meeting notebook, the

2014 financial disclosure forms, and I don't believe we need our ex-officio members, our non-voting members to fill that out, but all of the rest of you voting members, we need you to fill that out.

If you have any questions about it for me, just let me know. If you've already filled it out, if you could hand it to Barb at the break or just put it on the corner of her table, and if you haven't had a chance to fill it out and have questions, just let me know sometime after the meeting and we can go over it together.

The other thing that I wanted to point out, is Barb has been doing her best, but -- with all the turnover and membership just this past month or two, we want your help in making sure that our contact information for you is up-to-date, and also, the biographies that we have online for you is up-to-date. So Barb provided, behind your Tab 1 in your notebook, both the current contact information we have for you, mailing address, email, and phone numbers, and also, the -- a printout of your bio as it appears on the web.

Representative Higgins, I'm working with your staff to get yours, and Lincoln and Greg, yours aren't on the web yet, but I've been -- I've talked to each of you and I'm hoping to get those all updated this week, but if the rest of you could take a few minutes at some point in the next couple of days and review what we have for you and if there's anything that

needs to be corrected or updated, just let me and Barb know.

I think that's it for our business items. Does anybody have any questions before we just get started with the next point on our agenda? Yes, Mr. Morgan.

COMMISSIONER MORGAN: I thought you might mention one minute or two minutes about what we did yesterday.

MS. ERICKSON: What I would like to do, it's -- I hate to wait too long, but I'm going to do an update tomorrow on that -- on the broader initiative and since our time's pretty tight this morning, but I would just mention, we -- a few of you were able to join us and three of our members were actually, essentially on the panel of what we're calling now, The Health Policy Elders, in that group, we had 15 folks plus a number of folks from the public sitting in to listen, here in this room yesterday for half the day and had a really interesting and informative conversation about what was going on in healthcare and public health in our state during the '60's, '70's, and '80's, and we can share a little bit more about the reflections that we got from that conversation tomorrow when we talk about our health and healthcare in Alaska 2014 initiative. It's on our agenda for tomorrow morning. Does that sound good? Thanks, Dave, for reminding me to point that out, though, too.

So I'm going to get started and Craig, I don't think we need you up here quite yet, do we? Do you want to stay back

there and watch what I'm doing? I'm going to just take a few minutes to go over a little bit of background and I hope you'll forgive me, especially if you've been with us for three or four years.

I'm going to try to compact just very succinctly kind of where -- what we've been doing and some of the conclusions we've come to over the past three years, as we move into the rest of the morning where we're going to spend time talking about how we transition into kind of a new phase and a new role with the Commission.

So just for the sake of background, especially for our brand new members, while we had a chance to do a short orientation with you each already, hopefully, this will help fill in some of the gaps and we can answer some questions about where we've been before we start working on where we're headed next.

So just quickly, I -- reviewing our statutory authority, one of the things that we always provide in your meeting notebook in the front pocket, so you have it handy, if you want to refer to it, is a copy of the statute that created the Commission. So this is just a brief outtake of the purpose stated in our statutory authority.

Forgive me for a second, while I accept the webinar invitation, okay.

So the purpose of the Commission is to provide

recommendations and foster the development for a statewide plan to address quality, accessibility, and availability of healthcare for all citizens of the state, and one of the things our newer members might not realize is the Commission was initially created by Governor Palin under an administrative order during 2009, and met for several months during that year, and it was a smaller group at that point, but essentially, laid the foundation and created a framework that the new Commission, when it was created in statute in 2010, essentially adopted several of the members -- from the old Commission transitioned on.

So you'll find annual reports actually going back to 2009, where we really didn't get started until really late in 2010, and the Commission, as you know, is advisory in nature. All of the voting members are appointed by the Governor and we have three ex-officio members who help to kind of advise us from the perspective of the State Senate, the State House of Representatives, and the Governor's Office, and our statute also requires that we submit an annual report to the Governor and the Legislature, January 15th of each year.

So we -- and I don't know, sorry, the -- my computer locked up. So we operate, you know, our finances, since we're part of an agency of state government, our finances operate on a state fiscal year basis, but we operate, the Commission operates, in terms of the learning and the recommendation

development, on a calendar year basis our annual reports are all calendar year reports.

We have, as an advisory group, been focused on a role that really has been exclusively just study and advisory. We've spent the past three or more years trying to bring experts to the table around the particular issues that we've been focused on and we asked -- Ward referenced this a few minutes ago when we were introducing our brand new members, but we've always asked the Commission members, while the seats that you represent are designated in statute, we ask that you are bringing kind of the perspective and your experience and your knowledge to the Commission for those sectors you represent, but at the same time, that you're wearing kind of a broad community hat and helping us to think about what is, not necessarily the best solution from your particular industry's perspective, but for all Alaskans, and it was something that I think Jeff Davis would bring to our attention, more than anybody else. At times, he would go sit at another chair and put on his Premera hat and say, "I am representing now, the health insurance industry and my business, and this is what would work best for us," and then he'd come back and sit as his Commission seat and say, "Well, thinking about this from a community perspective and what's best for all Alaskans, I think we should do something else," just as an example.

We have focused, while we recognize the importance and

the interaction and interconnectedness of all the different parts of the full continuum of care and all of the different aspects of healthcare delivery, we've been very focused from the beginning on solutions addressing acute medical care issues.

We've been focused on problems related to cost and quality. We've been taking a statewide and a system-wide approach, and we have not focused on Medicaid at all, and so especially for our newer members, who aren't brand new, or any of our brand new members, this year, the one issue that we've addressed where we're coming up with findings and recommendations is fraud and abuse, and because our recommendations are targeted at state government and are about state government policy change, the one area where we felt we could really affect some change and make a difference was for the Medicaid program.

So this is the first year we've focused exclusively on the Medicaid program, just for that one issue, and that's why. Otherwise, we haven't focused particularly on any other -- any particular sector or any particular program. We've been trying to focus, really, on the policy level, what we think the state should do, and try not to get down into the weeds about how we think the state needs to do it, and have been focused on taking a proactive approach, rather than a reactive, so early on, we had a lot of push to react to and

evaluate the Affordable Care Act, for example.

We've done -- did a real basic analysis of it right after it passed and just as we were put -- established, but have not taken a particular policy position on anything there, and 2) we decided at the very beginning that it wasn't the Commission's job to take a formal position and to respond to any proposed state legislation. So state or federal legislation, we don't react to it. We're trying to develop our own solutions and strategies from the Commission's perspective.

I mentioned earlier that we've spent a lot of time in kind of knowledge development learning sessions and our approach to that over the past three years is to try to bring expert speakers to the table and also panelists of folks representing different parts of the healthcare system that might be affected by whatever the issue is we're talking about, and our process has been to try to be pretty informal and conversational and to avoid real formal process, and we spend time brainstorming after our learning sessions and working over email and trying to come to consensus to come up with our formal finding and recommendation statements, and then -- but we will use Robert's Rules for formal votes, and periodically, we use it, maybe not quite as much, when we get to a point of controversy where we need to really manage the conversation a little bit better, and all of our meetings are

open to the public.

They will continue to be. We notice and advertise all of them. We do our best, given technology problems periodically, to allow the public to access over telephone and email, or webinar, sorry, rather, so they can listen in, at least, and we always provide some time for public testimony at each of our quarterly meetings, and one of the things I'll mention, just so you understand the process that we'll be going through later today, working on refining and finalizing our fraud and abuse findings and recommendations for this year, that we have always allowed a public comment period during the month of November for written comment in response to what we've come up with in draft form for the year, and so when we finalize, we'll be finalizing in draft and we'll be voting at the end of that on our fraud and abuse findings and recommendations later today, but we'll just be voting to agree to release them as draft for public comment, and it won't be until November when we meet in a shorter meeting to review those, along with the public comments. So that's just an example of what our process has been all along and what we'll be doing there.

Just generally, our planning process has been real, you know, typical PDSA. We study. We spend some time each year, we have, studying conditions of the current system, but then also studying strategies that we think will address problems that we've identified.

So for those issues that we've studied, trying to understand the current system, we haven't been -- we've been trying to take a real solution-focused approach and haven't been -- haven't been trying to react directly to the problems we've identified, and we don't have a whole lot of findings and we have no recommendations related to the studies that we've done of the current systems.

All of the recommendations that we actually have, and most of the findings, are about what we've discovered in learning about potential solutions and that have -- and formed our eight core strategies, now that you see we have posters now, around the room about those.

Our vision statement is very broad. Our charge is very broad. Our vision statement is very broad, about ensuring, ultimately, we want to ensure that Alaskans are the healthiest people in the nation and have access to the highest quality, most affordable healthcare.

I've got a list of the studies we've done so far. We'll be adding our ICER study of employee health benefit practices to this list for this year, along with referencing all of the other studies that we're pulling together under the umbrella of Health and Healthcare in Alaska in 2014, the initiative we'll talk some more about tomorrow.

So these are about the studies related to our current system, and then, you know, we have, that you all have been

studying for your homework, and some of you, hopefully, are refreshing and going back and reading the set of policy recommendations that we have organized around these eight core strategies. I'm not going to review them, but -- in any detail right now, since you all have been faithfully studying them over the past few weeks.

This is -- I've been getting positive feedback so far about -- I was struggling a little bit in our -- from some of our earlier meetings this year with feeling as though I needed a way to capture, not in a 14-page narrative document, but a picture of some sort, that would convey the strategies that we've put together so far.

So this strategic map, I'm not going to go over it, I think we've reviewed it a little bit with our brand new members, and you all have seen this before and actually responded, one of your homework exercises a couple of months ago was to go through and make sure that I did the best job possible from your perspective, and I got lots of suggestions and made lots of changes based on the suggestions to make sure that it really was as accurate as possible, given -- we're trying to convey some -- these are really, really complex issues, and it's going to be really hard work to do any one of the -- address any one of the policy issues in any of those boxes, and how do we boil that down into just two or three or four words, is a challenge, but I think we've done a pretty

good job at this point.

I am going to suggest, and maybe we can talk about it a little later, I don't want to get bogged down in it now, I started off drafting this with putting the -- our vision statement in the central challenge and I don't intend in any way, shape, or form, we're not -- we wouldn't change our vision, but a strategic map like this should be focused on the actual problem that we're working to solve for the central challenge and it feels more honest to me and also more clear that we're not -- we haven't, so far, been trying to address the entire spectrum of all of the challenges that we face in this state with making sure we have the healthiest people and that folks have full access to the full continuum of care.

We really have been very focused on problems related to the acute medical care delivery system and concerns about affordability and variability in quality, and so I might suggest, and we can -- if we have time to talk about it, we can talk about it more and we can follow up over email, if we're going to start using this beyond just understanding ourselves, if we start using this as a communication tool with a broader audience, that it might be more clear to folks that's what these strategies and these policy recommendations are really intended to do. It's just a thought.

I'm going to skip over that and I'm going to skip over this. Actually, we -- I have a printout of this, and it will

be online, of this PowerPoint for you all, but one of the things we -- I just wanted to help make the connection, as we've talked about the problems, because I think that's one of the challenges with trying to take a solution-focused approach and focusing on the solutions, rather than focusing on the problems, is that when folks come to the Commission and look at our work, their focus is on the problems and the challenges that they're facing and they don't necessarily see the connection and they say, "Well, but we have real high medical prices here," as an example, "What are you doing about that," and that very much has informed, both some of the studies of the current system and also, the policy recommendations that we've come up with.

So this is -- I was thinking about taking a different approach to that strategic map as a companion piece to show how -- provide a picture of the problems we're trying to address, and again, this is not an exhaustive list of problems. There are a lot more problems that we face in this state, but just to help us think about going forward, this is -- these are the problems that we've been focused on trying to solve so far.

I think that is it for just a review of our background. If anybody has any questions about where we've been, before we -- and we'll try to get through that real -- this real quickly, before we -- because we're going to spend the rest of

the morning talking about what -- where we're headed next.

Very good. Thank you. Well, I think I'm going to turn it over to Craig now and then we'll start with the next part of our morning agenda.

MR. HOLT: Good morning, everyone. I do want to echo, it was a privilege to be in this room yesterday with the healthcare elders and I think you all should anticipate a really intriguing kind of summary of that tomorrow. So I want to thank you for that.

It's a privilege, also, to be here again. I think I was here last year working with you folks, as you were formalizing your core strategies and some of your priorities, and I think at that point, you were looking to potentially being sunsetted as a group, and it's really something when you are -- have been told your birth date and end date on the same day, as enabling legislation, and you were given new life and a new direction, and Deb asked me just to share briefly, have I worked with -- because I've worked with a number of boards and commissions over the years and actually served on some myself.

If I've -- I've seen a situation where you have a blended Board now of members that were from the onset with a purpose to basically set up a plan that could go on without the benefit of a Commission, but then that Commission continuing with an acceptance of the plan.

So let me say that again, because I think those two

points are very, very important. The previous Board, and some of the new members that are coming in, that Board's charge, the Commission's charge was to put together a plan that could stand as a directional statement with them being gone. Okay, so that was what -- that was what was put together, but the Legislature, and I think Deb and some others are going to talk about the legislative intent, the decision was to accept that, so accept the strategy and the direction that was given and continue with the Commission.

So in these kinds of cases, really, it's a transformational opportunity for the Commission, because you are -- you were set up to put a plan together and I believe you've been sanctioned and funded to go forward with more than just, "Now do another plan for us," because the plan was accepted, and so that's why this morning, and some of the homework you had, was then to focus on if you have a bunch of priorities, you have no priority.

Let me say that again. If you have a bunch of priorities, you have no priorities. To -- I think you all know, and you're all very busy people, it takes effort for you to attend this and put time into this. You have to focus your time and not -- it's the same thing with the priorities that you folks have. You have a number of them.

Dr. Urata and I chatted about this yesterday as we were walking out of the meeting, about the challenge for some of

you new members coming in is to say, "Well, let's take a look at the plan again. Is the plan good? Do we need to -- have we covered everything in the plan," and I encourage them, and I would encourage all you new members that the plan's been accepted.

The focus now is now, what can you demonstrate, what evidence can you show that progress has been made toward it? Okay, so what evidence can this Commission show in, I think -- is it a three-year enabling legislation? It is. What evidence can you show, and I would offer to that, you probably will have to have things underway within an 18-month window to be able to have that evidence to be able to demonstrate that the value that this Commission had was beyond just setting a plan, but also bringing focus to the priorities to be able to demonstrate something getting done.

So is this making sense what I'm saying? It really is a transformational opportunity for this Commission. So what you're going to see, as we go forward here, and this is -- there's a bit of tension here, because as a new representative, a new member coming in, I love the analogy of wearing the two hats. You're a Senator and Representative, if you allow, on this, which you are representing your specific -- but at certain points, you have to step back and say, "But overall," I think it was Senator Coghill who said, "We're the 20," I think that was the word you used yesterday. It was

wonderful. You're the 14 when it comes to looking at this, but you also have a very specific body of constituents you bring forward. So that's a delicate balance as you do that. So it's knowing when to use that at the right time.

As you look -- so as we look at these priorities and we start to bring focus, there was homework that was done for you folks to identify impact and importance, and we're going to be working from that as we go forward this morning. Please think of yourself as one of 14. Okay, so as you're looking at this exercise we'll be going through, think of you're one of 14, not the person representing your specific industry.

So is this making sense what I'm saying to you folks, as we go into this next exercise? Okay, all right. So with that, Deb, let me turn it back to you for maybe the next steps, as we go into the process or is Ward.....

MS. ERICKSON: Yeah (affirmative), actually, yeah (affirmative), I'd suggested to Ward, because we wanted to spend a little bit of time having a conversation about our different perspectives about why we think, and we'll look to our two representatives from the Legislature to help us with this, too, but I want to talk a little bit about our perspectives of why we think the Legislature and the Governor extended us for three years, and I asked Ward to start off with sharing some of his reflections, both of the legislative audit process and then some of the feedback that he felt he

heard from individual legislators, as well as from in legislative hearing, just generally, not specific.

CHAIR HURLBURT: When I came into my job a little over five years ago now, one of my duties was to Chair the Health Care Commission, and that was in the initial administrative order that Governor Palin had and then continued with the legislation that Governor Parnell fostered and the Legislature passed to have the Commission there, but I came to it with a skepticism about commissions that the particularly powerless commissions of what do they do, other than meet and talk, and some skepticism there, and have expressed that several times, and I think we've all felt that, that we're all busy.

We have busy lives, but that this is really important business that we're about, and so we -- our charge was pretty broad, but we have focused dominantly on issues of cost related to healthcare with value, with the other aspects there, but feeling that was a dominant need and that others were not focusing on that, and so we came to our sunset time, and this was my first experience going through a legislative audit process, and Deb and I, in meeting with the auditors there, both basically -- I said the same kind of thing, that if what the Health Care Commission is doing, if this process is being of value to the Governor's Office and to the Legislature, then we think it would be a good thing to continue, but you, legislative auditors, need to make a fair

assessment of that, because if it is not of value, the state doesn't need to look for the way to spend the money now, nor to have us take the time that we have, and so it was a collaborative process, and the report of the audit, the legislative audit folks was written up.

You've had a chance to see that, many of you. The major criticism that they had was that we had not developed a formal health plan and they kind of narrowly, I would say, zeroed in on that in our charge that we had not done that. There were a couple of other minor things, like how we noticed public meetings, which Deb and Barb and others had compulsively tried to comply with, but there was like we missed doing something by a millimeter or something and we're doing that now.

So we actually did pretty good, but there were a few comments like that, but on the plan, my own experience has been that health plans are documents that are put together with a lot of hours and a lot of time and a lot of paper and keep a bookcase from flying off the floor and hold it down.

So honestly, I've been skeptical of health plans, but that is our charge. It is in the legislation and Commissioner Bill Streur put it well in that he thinks we need an actionable health plan, and I think knowing Bill, his emphasis and focus is on the actionable part, and so we've been sensitive to that and I don't think it's going to have a big impact on how we've been approaching issues, but it will

formalize and capture things and document that for us.

Now, in talking with the auditor folks, as I say, it was very collaborative. It was a good process to go through. It was helpful and beneficial to us and we kept saying, you know, to make sure with your independent investigation that this is of value and worth everybody's time and worth the appropriation from the state to support it, and then when it got to the Legislature, it was uniformly supported and there is a growing group of legislators who reflect, in part, what's going on in our larger American society with the issues and concerns and all the articles in "The New York Times" and "The Wall Street Journal," and "Forbes," and "Bloomberg" and everything else related to healthcare and the changes going on that are becoming engaged and knowledgeable, but my own sense was gratifyingly, clearly what we collectively have worked on and done, is being of value and is helping us as we go through what's always a bit of a cumbersome process of how do we deal with it, and we're faced with the big budget shortfalls, the 2.5 billion dollars that the state spends, Medicaid, number one, employees, retirees, corrections, Worker's Comp, and so on, stands out there, and it's -- there are tough issues, but we're providing some resources, some ideas and some input on that, that I think will help clearly with healthcare and the unique and not only important aspects of that, but help with our overall state spending and stewardship of the tax payers'

dollars there.

So because the impression had been positive overall, really both the auditor folks and some of the members of the Legislature, probably somewhat rhetorically, but posed the question, "Well, should we authorize for eight years or should we authorize it for some other longer period," and my response was, I thought that the legislative audit process was well done and that it's important to hold, you know, we've got a plethora of commissions and boards and so in the state, but it's important to hold accountability there, so that it really is of value. So it just doesn't achieve a life of its own, and so I very much supported the shorter three-year time until we went through the process again, instead of saying, "Well, there are really good people on that and they're doing really good work, and why should we take our time to check it again three years from now, let it go longer than that?"

So it is another three years and then we'll have, I think, another objective look at, is this continuing to be of value to the state?

So I would like to ask maybe Senator Coghill and Representative Higgins if you could share from the legislative side any perspectives that you have and then we'll just have a brief opportunity for any of the other members of Health Care Commission, particularly those who've been on for a while to share your perspectives of this review and reauthorization

process.

REPRESENTATIVE HIGGINS: Well, you know, being the Chair of HSS, when the sunset came up and we discussed your, you know, the Commission, you know, there were a lot of people that asked exactly what you just said, you know, "What do commissions do?"

I mean, are we just studying to study? I mean, what are we accomplishing, and can the state afford that any longer, and what people, I think, are looking for, is they want answers. They want action, and you said it exactly right, though, if we're going to try to do action on all of these principles, we're not going to accomplish anything, and I've always said this, you know, you don't eat the elephant in one bite. You have to take small bites of it, to accomplish it.

The thing is, we have to focus, and just as -- and so as I was talking to my colleagues about it, I said, "We're, you know, HSS is 2.6 billion in this state." One-point, I think it's 1.4 is Medicaid, that's involved in it. It's pretty high up there. So the state's spending a lot of money on it.

So the real question is; how do we, as a state, take care of our people and how do we cover the gap for those individuals that do that, and how do we best serve -- serve us, and you know, how can we do that, and you know, of course, I have my own ideas how we can do that, you know, like everybody here, but what they want, right or wrong, is they

want action.

That's what they're looking for. They're looking for us to make a decision to give them focus that they feel the state is moving in and then we can tweak it from there, you know, is my point, and so I thought this Commission was very important in that role, and so I advocated to continue it, and I said, "Let's continue this group. I think it's important, and I think we can bring focus to the state," and my colleagues agreed with me on that. They said, "All right, let's do this," but they don't want to see a Commission that's just here just to do studies and whatnot. They want to see something come out of this Commission in one form or another. They don't know what that is like now.

I also serve on the Medicaid Reform Group, too, and so it's a different perspective because we're looking at Medicaid, not the over -- entire, you know, insurance policies of the whole state, and just as I'm listening today, this morning, you know, and fraud, waste and abuse, which is important, but that should not be the focus of this group. It really shouldn't.

Yeah (affirmative), we're going to save money if we do go down that path a little bit more, but that's not where the savings is going to be coming through. It's going to be case management issues for Medicaid recipients and needs to be -- we need to look at insurances and how can we pool our

insurances together for everybody in the state to make it work, and those are just kind of the couple of things that I see that we can work towards, but overall, I think the House and the legislators in Juneau respect this group and they expect a lot out of us, though. That's for sure. So at the end of three years, they want something. So anyway, those are my two cents.

SENATOR COGHILL: Thank you, and I wanted to hear what he had to say, because it's a fresh set of eyes. So from the Senate perspective, you know, I don't serve on the Health and Social Services Committee, but I have been a part of that discussion in some in-depth ways and I'm also on the Medicaid Reform, looking at ways we can do that, and we have some interesting things in Alaska.

We have unhealthy practices, unhealthy situations in Alaska that the Legislature is just not satisfied that we have gotten good answers and in a committee meeting, it's awful hard to take the in-depth look, get collaborative conversation such as you get here, so if your conversations feel like they're free-wheeling and don't come to the actionable items as quickly as you like, that's -- to me, as a legislator, that's fine, because we have to hear kind of that painful conversation so that when we go back to work in a committee on a specific bill that gets very narrowly focused, you have to have a context to it, and we have so many things that are good

tools, but we don't know how they all work interactively.

For example, we have, you know, private pay, that is the individual buying an insurance policy. We have the ERISA exempt. We have the Tribal Healthcare System. We have, you know, state and government employee benefit pay. We've got Medicaid. We've got Medicare. We've got TriCare, and they all kind of end up at the same locations and the docs have to deal with them and we don't have enough to have facilities for every single one, so they kind of blend into this very interesting mix, where people who are consumers of healthcare needs end up in this very interesting world of payment methodology that is hard to understand, and I don't know that in the Legislature, we can do it, so having the tribal, the federal, the various different groups represented, the docs who have to deal with the, kind of the avalanche of different paperwork, you know, so if we have, for example, a policy call that is on say electronic health records, you know, if the mandate comes down and it only can apply to one area, it might be a complicating factor that just is not going to work, but we may not know the context to it.

So to me, that's the value of the conversation here. How do you get pay per value? Somewhere along the line, we know that there's not going to be a lot of new money coming into the healthcare world. So we have to make every dollar count better. So we're looking at ways for that to happen.

We also know that between risky behavior, chronic illnesses, and just the new medical techniques that are available these days, we don't know that we can afford it all, you know. So we're looking for ways to streamline the way the insurance people work.

We're looking, for example, we know that the Medicaid world is -- we're trying to say, "We're the payers and we want to direct your behavior." Where on the private world, we're saying, "You have the money and a third-party is directing your behavior, but how can you get more choices in your behavior for payment methodologies," and they end up at the doc's office.

So to me, the real value of the Commission is to try to sort through some of those things that can kind of say, if you want healthier people, here are some of the two or three or five things that we see from this kind of a broad conversation that are going to be valuable.

So we're looking for that conversation, because when you have it in the Legislature, you have a bill introduced and everything gets narrowly focused on the verbiage, the policy call, yes, but then, I might have the docs and the insurance company having a big fight and go figure, right, and then it goes down to who has the best lobbying team, and sometimes, the context just can't get figured out under that circumstance.

So if you really want to help the people of Alaska, those two things -- that's -- a good dynamic in many, many ways, but it gets so narrowly focused that you can't broadly focus, and when we put together the Commission, what we're saying is, "Okay, we want healthier people and give us some strategies," because in order for us to get narrowly focused, we have to have kind of that context, and so I see that as the Commission's job.

Now, when it comes down to the actual action item, it's going to be hotly debated. There's not two ways about it, but if it has a good, serious deliberative context to it, it will be taken seriously. I've seen many, many times where a commission will come in and say, "After a year or two years of deliberating, we've worked on these things," and I like the strategy issues and certainly, we're going to pick one or two of them. You're not going to get them all. So you can't push everything through narrow canyons, but if we see one that pops up as a priority, it'll be picked, and so I can tell you, the legislators go there to do the best they can for Alaskans and we know that we're not doing them the best in the healthcare world right now.

It's just -- because it's -- it's a convergence of time in history, time in technology, the economics of our world just converge in on us, and then, of course, risky behavior just adds the whole deal to it, so -- and I can tell you,

every year, whether it's in the Health and Social Services or whatever it is, we're always told, "If you invest this dollar, you'll get $10 return in 10 years," but we don't know that and we have to take the shot at it, and then, of course, like Lincoln Bean said this morning, "We have guys my age coming into the long-term care situation," and the cost of that is going to be significant.

We've just got to figure out who's going to pay for it and how we're going to pay for it and if the generation that needs it can't pay for it, then the generation coming has to pay for it, but they've already been asked to do a heavy, heavy lift under the Affordable Care Act. So it's not going to be an easy one for us to figure, but those are the things that come to us in the Legislature and there's probably only narrow things that we can do. We want to do them. So I look forward to the conversation.

CHAIR HURLBURT: Thank you, both, very much. Any other members of the Commission with any -- we're running a little behind on time, but any perspective on this reauthorization process? David.

COMMISSIONER MORGAN: I did spend, believe it or not, or probably not -- I believe you would totally believe, I think, two-and-a-half hours with the auditors on the phone and I guess maybe I was a little bit of the problem, but hopefully, a lot of the solution, when I pointed out to them that when

you look at our annual reports, we do make a lot of recommendations based on facts and evidence.

So in my mind, and I also testified before the Committee on this, is plans, plans, plans, step one, step two, step three, A, B -- I -- what I liked about our reports was, I thought you could define it as a plan, if you look under our legislation, in that we're mandated to give a report with certain recommendations and steps, and we've done that scrupulously since I've been on the Commission.

So we don't call it a plan, but in my mind, it was a hybrid that produced a plan, and the other thing I pointed out to them, and I think we forget that an idea is a powerful thing, as Marcus Aurelius would say. In my five years, including a year of just out there at the other Commission, and giving presentations, a lot of the things that I'm beginning to hear in the last year at Commonwealth North and Chamber of Commerce were being discussed out there in the back of this room, like VA situation, and some other issues that are coming up, and yesterday, while we were having our little elders conference next door, I bounced over to a Commonwealth North presentation on, and guess what it was finally, and I've been going -- I'm a member and I've been going for five or 10 years to Commonwealth North, they suddenly discovered that cost and quality may be an issue in healthcare and had a speaker basically detailing out what this Commission looked at

two-and-a-half years ago.

So plans, schmans, in my mind, just having a forum where there's some rules where evidence and numbers and metrics have to be there to even start discussing it, and then recommendations, and I think it's -- like last night, I was just sort of looking at old ones from two or three years ago and then looking at the recommendations, I think we have had more of an impact, even though we don't have authority, necessarily to tell anybody what to do, but we -- I think we have done a lot of jaw-boning. I think we've talked to a lot of people and sometimes, we're probably thought of as a nuisance sometimes, when we're bringing messages that are not necessarily so popular, but I think in the long run, it's been a net positive and we've brought stuff to the table that has now begun to have an effect.

I visit the Legislature three to four times a year and I see our report on desks with little yellow tabs in them, and when I'm talking to different legislators from all over the state, they ask me questions about what's in it. So they're reading it. I think it's helping and listening to other organizations where we've done joint programs with, like Commonwealth North and the Chamber, but I think our reestablishment to go on for another three years, which I agree, I hate these -- after a while, a bureaucracy builds up and you start just doing stuff to make a checkmark in the box

and then you destroy whatever credibility you have.

I think the ideas we brought and the recommendations we've made have had an effect, slowly, insidiously as one person told me from another lobbying group, insidiously. So don't sell ourselves short. I do think we have an effect and I don't think we -- I think we have done a pretty good job with what we had and the mandate and the authority we got.

Maybe we got more done not being required to give an A, B, C, D plan, but to give recommendations based on the evidence coming here. So that's my 10 cents' worth, whatever it's worth.

CHAIR HURLBURT: Thank you, David.

MS. ERICKSON: Yeah (affirmative), I was going to say, maybe that is a good transition to our next phase, which is the three-minute speeches.

CHAIR HURLBURT: Yeah (affirmative).

MS. ERICKSON: And should I just introduce real quickly and remind folks what we're doing? So we've been through the process, and you have behind Tab 2 or actually, it might have been in the packet that Barb gave you of the additional handouts, actually, but I emailed this to you all on Friday, as well, the first exercise that we all went through together over email to rank our 27 different groupings of policy recommendations by both importance, in terms of driving toward our vision and central challenge, and also impactability, and

that is what we feel the Commission, what you all feel the Commission could make the biggest difference in, in terms of driving implementation and action around those recommendations.

So based on that first cut, what we've done is we came up with the top and ended up selecting everything that fell on or above the line for importance. So we've narrowed down to what is now 15. There were actually 17 of the 27. Some of those policy recommendations are duplicate because they kind of -- they show up under multiple strategies. They're more kind of foundational cross-cutting, and so I took the duplicates out this time.

I wanted you to be able to see the 17, but I grayed out two of them, just because they duplicate others. So now you have this list of 15, and what I asked you to do in the email, we'd given you warning a few weeks ago that you're going to be asked to give a three-minute speech, but essentially, we want to go around the table and have you each make a pitch for at least the top one, if not the top three, depending on how many you can fit into your three-minute allocated time, which one, two, or three of these 15 do you think, and since we picked the most important, I think now, we want to focus more on what you think the Commission could do over the next couple of years to make the biggest impact on actually facilitating, in some way, implementation of these policy recommendations.

There was another part of the exercise with this other table where I asked you to submit suggestions of what you think that could look at. I did that, as much as anything, to kind of prime the pump for you all. A little bit later, we'll have a conversation of what the actual action will look like. We don't need to pull it off this list. It was mostly to get you thinking about what Commission action to facilitate might look like, if it's serving as a convenor around a particular policy issue and facilitating the payers and providers to work together on a particular initiative, whatever it might be, but moving into this action step, what can we actually do.

Just so -- should I explain the rest of the process, too, that they're going to be voting. I should let my facilitator do this, probably.

MR. HOLT: Yeah (affirmative), thank you, Deb. Real quickly, so -- and a reminder, by definition, these things you've written on there contribute to your core strategies, so by definition. What we're focusing on, and you've heard it, and I appreciate the perspectives from David and the Senator and Representative and Ward on what the next three years might look like, because pretty much, it was about demonstrating that this group had an impact on big issues.

That will separate this Commission from maybe other just ongoing boards that convene and so I guess that's the challenge for this Board, this Commission, excuse me, this

Commission, is to be able to have that evidence that shows and thus, why the focus on the priorities.

So just because we're identifying these 16, you've all identified them as being important, now we're trying to say which of these do we feel, frankly, that within, I'd say an 18-month, maximum two-year period, you could actually have an impact on and then have some measurable evidence on that? That's the focus this go-round.

So as you're -- and think of this as one of 14. Again, please, try and keep that at this exercise of one of 14. So as we go around, we're going to ask you to talk about -- only of these. So please honor the process at this juncture. Go ahead, Deb.

MS. ERICKSON: One more thing, too, I wanted to point out and remind you all, just because we select a few of these to work on as a group, this is -- what we're doing is identifying what we're going to spend our time as a group in meetings and our resources focused on over the next couple of years.

It does not mean that other policy recommendations are not being addressed in other ways by other groups. We'll meet with the HR leadership network later today from some of the non-healthcare industries that have been concerned about some of the issues we've been addressing and they're taking some of the recommendations and working through their own channels to try to effect change, just as one example.

We can talk a little bit more later about what the Medicaid Reform Advisory Group is doing and how some of their recommendations and the direction they're taking, where they align with the Commission, and how that work might align with ours, just in terms of action steps, too, but I just wanted to point out, we're not taking these off the table.

We're not -- the things even that fell below the line aren't not important, and they're not -- there still could be work happening. We're just -- they didn't go away. We didn't demote them. We're just trying to go through an exercise to pick what we're going to spend our limited time and money on over the next couple of years as a group. Dr. Urata.

COMMISSIONER URATA: You answered my question in your last statement or second to the last statement.

MR. HOLT: Okay, and again, this is about focus. That's all this is, and there's a myriad of ways to do this. We're trying to honor the different ways people think, as well as the group dynamic. So what we're going to ask you folks to do is give your pitch, and honestly, if you don't feel strongly about them, you don't -- you know, you can yield your time to someone else.

This is -- you don't have to do this piece, but if there are, then we ask you to do it. This is going to result then -- once we finish the exercise, then -- have any of you ever have been in a process of dot voting, since you've been in

junior high?

Okay, so what we will be doing, is a very non-technical, but highly effective, interactive session. Does that make sense, what I just said? Where we will actually be giving you folks five dots. We have -- we will do a reveal, because behind of each of these placards you see on these flip charts are actually the 15 priorities, and we will have you go around and vote, after you've listened to your counterparts, which ones you feel have -- will be the most impactful, meaning that this Commission's work will result in measurable benefit in an 18-month to two-year period.

Okay, so that's what I'm going to ask you to do, and I'll just mention, you know, just so we can get it out of the way, you can only use one dot per vote. So this isn't one of those where you get together with three other people and then just stick all five of them on there. Although, I do like that sometimes. That's not what we're doing today. So it is going to be one vote per -- so does that make sense?

I just want to let you know where you're headed with this. So as you're listening, you might be thinking about that. Any questions kind of about the process of what we're going to be doing? With that, then why don't we just start at the -- you pick and then let's just go around. You're going to be keeping time, correct?

MS. ERICKSON: I have my stopwatch set.

MR. HOLT: Okay.

MS. ERICKSON: Would you mind if we start with you, Susan? I was looking for one of our longer-term members to be on the end of the table at some point, but they're all sitting in the middle, so.....

COMMISSIONER YEAGER: Okay, the good news is I'll get it over with, but and also, sitting at the head of the table, but so I'm happy to. Just quickly, with lack of time here, another hat I wear is the host of the Alaska Federal Health Care Partnership, which does include members and leadership from the VA, the Indian Health Service, the Alaska Native Tribal Health Consortium, the Army, the Air Force, and the Coast Guard, and so we meet regularly about how to support our beneficiary population, which at many times will have multiple eligibilities, be it Alaska Native retired person, three different eligibilities for healthcare and how does that all work?

So thinking about that and thinking about what's going on in the VA, and how we do business now in the VA, we use -- half of our budget now is purchasing healthcare in the private sector. So half of our budget, over 100 million now, buying healthcare in the private sector. The other half is providing healthcare ourselves through our own clinics, and so one of the things we feel is the most important, I feel, is the Priority number eight.

It's VIII.4 -- VIII.A.4c, Health Information Infrastructure, and the reason I feel it's -- it hits many of the -- our priorities of access, quality, efficiency, because it really speaks to communication and as we have our beneficiaries throughout different sectors of healthcare, federal, community, private, Native system, what we're finding is, is that information -- we need to share the information, and so we need to have like the tying in -- we work closely with the Alaska E-Health Network for developing an opportunity that we can all enter in the portal, pull information, as needed, in support of a beneficiary episodic care, and so establishing -- really furthering that and having a statewide process that integrates the private sector, the community sector, the federal/state, in support of our beneficiaries to move the medical information, as needed, when it's needed in a way that it can be utilized in support of the patient care.

It also reduces, we feel, like multiple, you know, poly-pharmacy issues, duplication of tests, information that may be pertaining -- let's say the person has diabetes and so it's important for the other provider to know that they have diabetes and what other tests have been conducted.

So we think it's -- in order to get better value for the dollar and really increase the access to care, the quality, care, and efficiency that this Priority VIII is really important for us, as our number one.

The second one, and I'm just going to do two in the time, when you look at all of these, you know, they all relate to our population and they're all very important, but in Alaska, we feel, because of the difficulty in travel to receive care and the geography and the expense of travel, the weather, et cetera, that further developing a statewide program of telemedicine that will reach, get that expertise to those beneficiaries, no matter where they live in highly rural areas, infrastructure, connectivity, and we're pretty good, really, and we have room to go, but considering our state and the rural nature of it, we have a lot of bandwidth out there and continue to get more, so telemedicine can leverage that expertise into the rural areas into even -- into Alaska from the Lower 48 for highly specialized care that's needed and even just primary care support, especially behavioral health, as we see our beneficiaries going back to rural villages post military with all the TBI, traumatic brain injury, post-traumatic stress syndrome, and it creates -- adds to the suicide rates and the domestic abuse and all the other -- many other social problems.

So we can actually, want to leverage the technology for tele-behavioral health to support our beneficiaries, no matter where they live in Alaska, utilizing all of us as partners and sharing in that for taking care of these people, who are not only federal beneficiaries, but they're also state residents,

et cetera. So for us, that's number two.

MS. ERICKSON: Thank you, Susan.

COMMISSIONER YEAGER: That's it.

MS. ERICKSON: Good job.

COMMISSIONER STINSON: Wearing an Alaskan hat and having been around for all of this, I'm going to quickly hit a lot of different points. I think V., the Foster/Support Patient-Centric Primary Care, as well as the second part, Patient-Centered Medical Home, we've heard over and over again, that is reproducible.

That's worked in other states. That has saved lots of money, increased availability, increased quality of care. That's got to be -- that's got to be number one.

Now to go through the rest quickly, evidence-based medicine, I think everything on the list is a good topic. The problem with evidence-based medicine is whose evidence and who's going to interpret it and that's where the devil's in the details.

The same thing with transparency, as we've talked about. How many different systems are going to come online? Is it going to take the private sector, the public sector, the federal sector, everything? There were difficulties with that.

Pay for value, defining value is much like defining evidence-based. It's in the eye of the beholder and I -- and

again, let me say, all of these things are good. They're not as low hanging fruit as the primary care, patient-centered home. That's a high value, low hanging fruit.

Modify insurance regulations, again, these are all good points. Focus on prevention in a lot of ways, I think Susan's points on telehealth, I totally agree with them, and I think it's as important for prevention. It keeps people from coming in, transportation costs for an earache that can be taken care of somewhere else.

So again, all good, and one that, as you -- as Ward probably knows is kind of near and dear to me, even though maybe not to others, adopt opioid control policies and programs, because in Washington State when they did that, that dropped prices across the board, ER visits, domestic violence, suicide, abuse dropped across the board, huge savings. It helped people's lives. I think that's another thing that cannot be underestimated.

COMMISSIONER ENNIS: Thank you. One of my top three has already been addressed by Larry. He was just talking about opioid control. It was interesting going through this process and there were a few, I thought, were very impactable and very important and some that were not impactable, but important and vice versa, but opioids, I thought we could make a big impact and it would have a big difference.

I think that if the -- if this body stands by its

recommendation of we need to encourage the state in all of its state programs to control reimbursements, using kind of evidence-based medicine on opioids, I think that will drive immediate savings to the state and ultimately, increase behavioral health in the state, too.

Next, for me, is Worker's Comp. This is significant. We're number one in the nation on Worker's Comp rates and we're there because of state regulations. That is a big part of it. Now, a lot of it is, of course, just the cost of healthcare in Alaska, but state regulations are a driver, as well.

What this body can do is we can invite information from other states. Someone in the comments mentioned Wisconsin. I know Montana recently changed regulations, as well, and Montana went from number one to number 11, so we're back at number one, as far as rates.

We can invite information from those states and see how that -- how those regulations have changed and what, if any, what the unintended consequences were and how we can imitate that. We don't have to reinvent the wheel. We can just do what's worked for other states and this body can vet that and forward that information to the Legislature.

Next, so this would be number three for me, is insurance or modify insurance payment regulations. This body has identified a very specific regulation that appears to be

driving some very significant costs in this state and as examples, we've pointed to things like medivacs and certain kinds of heart conditions in this state, and that's -- so we can drive a very significant impact.

We heard from our legislators today, ultimately, what they want is they want something narrow that they can actually act on, that they can defend, that makes sense, that they can explain, and that's what they need, and that's what this -- that's what the insurance regulation does. We give them something so specific.

Worker's Comp, we're not quite there yet, but we can be soon, and for opioid control, I think we can be there very, very soon, as well.

COMMISSIONER ENNIS: Well, my number one recommendation is the patient-centered medical home model, such as Larry has talked about. We spent quite a bit of time learning about the model a couple of years ago and we've seen in other parts of the country, there is evidence that this is both beneficial to patients, as well as cost-saving.

The second part of this approach also is the integration of behavioral healthcare with primary care in a manner in which a team can provide much more support for a patient. We've heard our primary care doctors talk about the fact that behavioral health patients are overwhelming their practices and not only that, but they feel inadequate to provide the

necessary care that they require.

Having a care manager as part of a team and the patient-centered medical home could make a great difference in assisting those patients and following up with their care, understanding their medications, perhaps even leading them to other resources in the community that could keep them on track.

The behavioral health patients are currently frequent ER visitors. Again, a very expensive form of care, as well as, they do often call on our emergency responders and our police to help them. So again, having a more comprehensive, holistic approach to helping those patients will make a great deal of difference.

While I was thinking of this patient, this particular patient and the primary care patient-centered medical home, I realized there are a couple of other patients that could benefit greatly from this model. Number one, the patient is -- are growing number of seniors and in that case, we all recognize, as you grow older, your need for medical care becomes more frequent and more costly.

Often seniors are confused about their medication. They have a lot of medications. They mix them up. They don't understand the lab work and the tests they may need. They don't get those done in a timely manner. Again, with care management, I believe our seniors can greatly increase their

health, prevent their more frequent visits to doctors and they're also frequent visitors to the ER, and most importantly, help them remain at home, which is much less expensive than out-of-home institutional care.

The same thing goes for families who are care givers, families who have disabling -- members who have disabling or seriously medical complex conditions. Again, a very difficult role they plan in monitoring the medical care of their family members.

The patient-centered medical home can, again, with care management and other resources, make a big difference in their lives, help reduce those costs, and again, most importantly, keep that family member in the family home. So again, my number one recommendation for actively pursuing some support and more opportunities to show that this model works in Alaska, I believe is very important. Thank you.

MR. PUCKETT: Good morning. I have two that -- my priorities are two of them are more of a big picture and then there was a low-hanging fruit. One of the big pictures is -- I think a top priority should be incorporating evidence-based medicine in the health insurance plans in the state.

By their very nature, health plans need to evolve and change. Technology and treatment in the marketplace changes. It's prudent and sensical that health plan administrators use decision-making processes that are based on what has been

proven to be most effective and also bring the best value for the patient, the providers, and the plans.

I notice concern about, well, who's going to decide what to use. I think that would be made -- that decision would be made by the individual health plans, private, government. They'll decide what evidence they're going to use to make their decisions on.

A major challenge for everybody that's concerned in this issue is being educated about and having the resources to remain informed of what is the best evidence-based practices. While price and quality and transparency are critical for effective healthcare consumerism by everybody that's getting healthcare, the impact of those two topics would be greatly diminished unless the coverage and the provisions that are in the health plan are known to produce the best results and the value.

I believe evidence-based medicine would be one of our easiest of the recommendations to make a compelling tact for implementation. There's a lot of information out there and a group like ours would be the one to vet it and to work it forward.

Another big picture item I think should be a priority was pay for value. The policy and decision-makers need information, and while information is certainly more than just data, modern technology enables us to effectively, thoroughly

and quickly mine the data, coupled with appropriate business decisions, methodologies and participation of the invested and engaged stakeholders, better decisions for improved quality measures and payment structures can produce, what I saw, more nimble consumerism and market changes.

The nimble changes will lead to better value for each person in our -- and used in our healthcare dollar in the experiences of those participants, and then what I considered a low-hanging fruit is changing the statute and regulations for Worker's Compensation.

The state's Worker's Compensation rates are strangling Alaska businesses, even driving some of them out of the marketplace. As a business owner before I joined the state, I saw that literally happen before my eyes with vendors that I worked with.

The current -- the Worker's Compensation structure leads to suboptimal results and very poor value for the patients that are being served by Worker's Compensation, the providers that are providing the services to them and the payers who are paying these exorbitant rates. If health plans do not change with the business and the healthcare environment they operate in, they will atrophy. It is past time for the state of Alaska to make changes, necessary changes to the Worker's Compensation statutes. Thank you.

MS. ERICKSON: Thank you, Jim.

COMMISSIONER BEAN: Can I try this? Forgive me if I stumble and fall. I'm going to focus on prevention. While you guys speak to all the other things that are important in this table, I serve on the National Indian Health Board with diabetes and we -- I work with that formula that distributes all over the United States and my community, alone, in '71, there was one diabetic in Kake. Today, there's over 80.

Prevention is still the best medicine. If we had focused on prevention to fight obesity and all those other things and better lifestyles and lose weight, and control our healthcare, we wouldn't be dealing with most of what we're talking about today.

Although, I don't have three, I see a whole bunch I'd like to pick out. Prevention, from the tribal side, for the state would be to say that is still the best medicine. Thank you.

REPRESENTATIVE HIGGINS: Well, you stole my thunder, Lincoln.

COMMISSIONER BEAN: All right, I'm sorry.

REPRESENTATIVE HIGGINS: Now I've got to think of something completely different, but actually, you know, being in the dental field for many years, Lincoln is entirely correct. Prevention is the key to our bringing down the cost of healthcare in the state and we need to work on that.

What a lot of people don't understand is in the early

'70's, Alaska was number one in lowest caries rate in the nation, and over the years, we're now the highest caries rate in the nation and the question you've got to ask is, "Why? What happened," you know, and of course, our lifestyle has changed. Our food changed and we have more refined sugar in our diets that we've ever had, you know, but what are we doing about that and so education is important to our people, and we need to do that and we need to focus on that to get out, you know, and I've heard the comment, that you know, you can legislate all you want, but people are going to do what they're going to do, and so it's hard for us, but that doesn't give us, you know, that's not an excuse not to educate people. So prevention is the key and we need to continue to work towards that.

There's a lot of really good ones here, and you know, I'm always looking for multi-player collaboratives for statewide insurances. I think that's important. I think we need to look toward that. There's -- I brought up the gap people all the time and so that's important and I think we need to look toward that.

Someone mentioned reform on Worker's Compensation and you're right, it's strangling our businesses in this state and we are looking at that and we took some legislation last year on Workman's Comp and so we're going to continue to work on that, too, but those are -- in my estimations, are our top

values that we need to look at, you know.

You brought up telemedicine, very important for the state and we need -- because our state is a unique state and that's the thing that nobody understands that in the Lower 48. They don't get it. There's 720,000 of us, but we have the biggest state in the Union and for us to go to everybody, we can't do it. It's just impractical and so we have to have telemedicine and we have to work different, completely different. Our physicians have got to think outside the box.

You know, the Native communities and the villages and all -- and everything, they've got out there, we've got to really help them with telemedicine and work, and they're working toward that and they're doing a great job, too, and they've come a long ways in the last few years as far as that, and they're kind of a model to us, to a degree, and we should actually look at what they're doing and work toward that in ourselves. So those are the areas that I think, you know, we should focus on. Thank you.

COMMISSIONER URATA: So I'm going to add to the thunder and that is, my first priority is preventative medicine or preventative -- focus on prevention, and the reason for that is like, for example, heart disease, 80% of heart disease can be prevented, you know, heart attacks, hypertension and you throw in obesity, diabetes, and -- but the focus that we have is that we're reactive medicine. Once you get the disease,

then we treat you.

We need to be proactive. We've got to -- we have to teach people to live health lifestyles before they go into the bad things, and I think that starts at the schools, elementary schools, and some of the things, and a lot of this is from my volunteering with The Heart Association, is that we should have PE for schools.

Now, I know that's really a tough thing to go, at least politically, but that's -- how are you going to teach the kids that they need to be active if you don't do physical education every day, or whatever it is, and they need to have some sort of a health class or curriculum where they learn what are the good foods and things of that sort, and what's a healthy lifestyle.

If you don't teach the kids, how do you learn, and -- or actually, that's probably the best time to teach a person is when they're kids. I kind of got it mixed up there, so -- and then once you're an adult, then you have to do, I think what's helpful is wellness programs, and I think some of the insurance companies are doing that, but you have to have incentives to participate.

So the other area that I thought was important was price transparency, because now patients don't know how much things cost and they expect that the insurance companies will pay for it and they're surprised when they get their bill, and I think

it would be helpful to have more price transparency.

All payer claims database may be the solution, but I'm not convinced on that, based on what we've seen so far in other states, but that, theoretically, seems to be the best solution. So those are the two things, and I also agree with all the other stuff that's been presented already. Thank you.

SENATOR COGHILL: I could say, "Me, too," to so many things. The prevention, I totally agree with in many ways as a priority, but the question is, "How do we get there," because, you know, the problem we have is in our world now, people are going to have to take more responsibility for their health and well-being.

They're just going to have to, and the way it's going now, the responsibility is being shifted to them under some circumstances and taken away from them under others. So to me, how to get there is going to be probably what we can do with price transparency and pay and value, because if you don't know what risky behavior's going to cost you, and I understand the education part, but at the end of the day, if you know that you're going to have to pay for it, something's going to change and so to me, I kind of head in the direction of increased price and quality, and pay for value and I don't know how to get the best ones out of there.

The word for our generation is collaborative and probably somewhere along the line, we're going to have to have that

multi-payer collaborative that just kind of hammers out some of the wrinkles between the federal system, the Native system, the Medicaid system, you know, how do we iron out the wrinkles, and it's probably going to be a process. So I put down important, and probably as close to impactful.

I started by saying, "Evidence-based medicine," but I've kind of changed my mind a little bit after doing a little homework last night, because I think the devil is in the details, the who decides, you know, we need to give the consumer better decision-making information.

That is true, but if the evidence-based medicine is saying, "Here's the suit and you've got to wear it," if you're a size 48, that's great if you have a 48 suit, but if you're a 32 and you're putting on a 48 suit, it ain't going to work, and I don't know. I began to think about that last night. I'm not 100% sure I would put that as my highest priority.

The most impactful, I think, I put down the opioid control and the Worker's Comp, because that's the most -- that's the low-hanging fruit. That's got to be done. It's just got to be done, but I think getting the information to the consumer early on, and I agreed with what Ward said earlier on the statements on the healthcare, that is so late in the game and so confusing, we've got to get it closer to when you need the service, here's the value and here's the cost of that value.

We've just got to get there and so whatever we have to do to increase the price transparency and the pay for value to meet is just top notch. We've just got to get there somehow and so when I'm listening to us here, what it costs you, whether it's risky behavior, how do you pay for it, and where do you get that value, or to me, the big deals, and so right now, it's so confusing to an elder. It's so confusing to a 24-year-old person. It's so confusing to somebody who is just beginning a family. It's just not good information coming to them, knowing that they have a whole system out there to serve them, but they don't know what the value is to them.

MS. ERICKSON: David.

COMMISSIONER MORGAN: I guess wow and ditto, I guess. I guess, instead of recapping, because I -- especially on all-payer database, transparency, and evidence, again, it's always the devil in the details. I think an underlying, as an economists, I've got to go to what I know or what I do, all of us, everybody is an economist, they just don't know it.

They make rationale decisions on what's best for them in their mind and what it's going to cost them, and that graph can go up or down, but as you make that spiderweb effect of cost and benefit through the process, I think providing as much -- at least data on the major activities of what is -- what does it cost? What are you going to have to pay, and making that relatively available is actually, with the change

in insurance is becoming much more important, in order to make -- those that do make rationale decisions, until the problem with elasticity of us getting there of that impact, that won't change that much. That's more of a long-term. I do agree.

I think the things you mentioned in the short-term, opioid activity, dealing with the opiate and the other issues, yeah (affirmative), the short-term, and the long-term, ACA and those other enactments are going to force us to get into those other areas.

Hospitals, I believe, if not next year, the year after, have to actually produce their price list. I think they have to put it on a website or get it out. I can't remember if it's two years out or three. Community health centers have always been mandated to provide their price for services, since the beginning of the program.

So it's not that nutty of an idea to the community health centers. It's sort of they've always had to -- they were required as to what does each unit cost that they provide or charge and what do you charge, and put your provider mix in, come up with what you're going to do and then anybody can walk into a lobby or look on the wall, and yeah (affirmative), it's $280 for a primary care visit, and then there's a sliding fee scale and these are the rules.

So I'm kind of used to a different -- a little more transparency in that regard, but you're not going to affect

medical home and even behavioral health, because the big problem has been everybody loves the idea of integrative behavioral health or medical home, but our reimbursement system, whether even for community health centers is based upon how many you do, not necessarily the quality of what you do and mixing in the cost of the behavioral health activity in the visit. It's always two separate medical records, two separate diagnoses.

You go into a medical home and it's a behavioral health problem and a medical problem, you still have to provide two separate diagnoses, two separate medical records. So we talk.....

MS. ERICKSON: Three minutes are up, Dave.

COMMISSIONER MORGAN: Okay, so the point I'm making is, if you really want to change this stuff, you've got to change that kind of stuff and you've got to change the way you reimburse for it or it will never happen on the provider's side.

COMMISSIONER LOUDON: My intent was to listen more and speak less today. One thing that -- I have a lot of opinions about all these issues we had, but the one thing I don't have is context. I haven't been with you all for the last several years and I don't know exactly what's been discussed or even the meanings of some of them, but I did use my now well-worn -- I dropped this in the mud, Deb's -- I was kind of hoping

we'd have a scatter plot graph of where everybody's -- you do, good. That will be useful, just to find out what everyone's priorities were and how they felt.

There are a lot of things on this list that I think are incredibly important to the state. Some may be very important to state government, but I didn't feel like our Commission had the ability to impact the state healthcare model by doing some of these things, so I ranked them lower.

The few that I did that I had both important and impactable, transparency legislation, something everyone's talking about, I mean, the ability to know what you're getting for the money that you pay is very important, and the others, the modify insurance payment regulation, the one specific regulation that we know that's caused a lot of problems with specific pricing.

CHAIR HURLBURT: Thank you (indiscernible - too far from microphone).

COMMISSIONER HULTBERG: Thank you. My apologies for being late. I told Deb and Ward earlier, this was difficult to rank, and actually, I did my first homework exercise and I have to admit, I was delinquent in my second, sort of like choosing among your children. You just don't do that.

So I found it a little difficult to actually prioritize among the narrowed down list, but I'll speak to a couple of things. First of all, I think evidence-based medicine, it's -

- Ward can probably say how many years it is from the time a discovery is made or a treatment is viewed as effective or not empirically, to how long it takes for that actually to be adopted, and I think one of the things we can really work on is accelerating knowledge transfer and it's something that hospitals are doing.

You'll hear a little bit about that tomorrow through a mentors for quality program, but really accelerating knowledge transfer in the area of quality, I think is something that's incredibly important so that we don't -- so that we can reduce the number of things that are done that maybe aren't necessary or harmful.

The other two I will speak to, focus on -- under focus on prevention, I think integrating behavioral health and primary care -- behavioral health is just really emerging from a lot of areas. I'm hearing a lot of discussions about behavioral health and the needs we have in our state to really focus on the issue of behavioral health, and then opioid control policies and programs.

I heard a presentation that's kind of -- a month or so ago, that has kind of sensitized me to this issue and that opioids are now the number cause of accidental death in the country, and we have a logarithmic increase in the number of opioid-related deaths, and so I think that is -- that's something specifically that this Commission could work on.

I don't want to -- so those, I think -- if I had to focus on two categories, it's evidence-based medicine and focus on prevention, but I don't want to -- I can see I have two minutes left because I'm -- or one minute left, because I'm sitting right next to Deb.

So I'll use my one minute, though, to say a little bit about payment reform. I do think payment reform is incredibly important. I think the state has a role. We've been talking about that in front of the Medicaid Reform Advisory Group, that really, how Medicaid pays and sitting down and having long conversations over the long-term about how Medicaid pays is something that's going to be really important going forward.

The landscape looks different in the future. We all know that. How we get from one foot on the boat or from being on the dock to being in the boat is really the question, and I think that's really something that we do need to grapple with. Whether this Commission can really impact that, I'm not really sure and so that's why I didn't put that as one of my top three. However, I do think it's something that's incredibly important.

Transparency legislation, probably -- I think something we need to approach very cautiously because of evidence in other states. Does it move the needle, and where is payment reform going, and if we're moving beyond consumerism to global

payments, I think is the question, "Will we be moving beyond consumerism to global payments," and I think that's a question we need to ask ourselves.

CHAIR HURLBURT: I picked my priorities partly in the context of what are some of these things that I absolutely think are important, but that maybe others are doing and championing, and so what unique role might we have to play, and I picked the three with totally different reasons for the first one and the second two.

The first one was the evidence-based medicine, and I would say partly in response, Larry, to your comments, I think that there is a real discipline around evidence-based medicine now and an understanding of grades of evidence, so that we can deal increasingly with the reasonable skeptical challenge of, well, who's evidence is it, and I think in many areas that we can.

This Commission in the very first meeting when I was six months -- six months before I came onboard, though, heard that 30% or so of what we do in healthcare either does no good or does harm, and then the general estimates are in the 30 to 40% range and the reasonable retort is someone says, "Yeah (affirmative), but we don't know which 30 or 40%," but I think that we increasingly can do that with evidence and I think that in our benefit design for payers, for employers, for health plans for the state, that we can design our benefits

more to be based on evidence, that now, we provide benefits.

For example, Overlake Hospital in Bellevue, which I think is a really good hospital, I was impressed while working with a health plan and rounding there, but well, a nurse, who was in charge of their Care Coordination Department there, one time made a comment, just we were -- a personal conversation in a meeting, "Well, I've got my annual year, my insurance plan is almost up and I've got four more massage therapy sessions that I'm entitled to. So I'm going to schedule them."

There are things like that, that there's a public demand for that there may be lobbyists representing a professional group that lobbied for that there is no reason to cover that way and it can be elective purchases on part -- that people have. So I think that we can have better benefit design based on evidence.

There are other things that are commodities that we provide under health insurance that it's not disaster coverage, but it's the same as when you buy your automobile insurance policy, why not throw in gasoline, and you know, it will raise your rates, but it also impacts whether you decide to -- there's a really good restaurant up in Fairbanks and let's get in the car right now and we can make it for a late supper and then drive back, and it's not too expensive when somebody else is paying for the gas.

So I think that evidence-based -- that that's important, and in a clinical setting, again, yesterday, George Rhyneer said, "You know, every patient is different is true," but it informs the clinical decisions there and I think this is the holy grail. I agree fraud and abuse should not be tolerated. It should be weeded out, but it's limited. It's a small number of bad apples.

Pricing, low-hanging fruit, in Alaska, where our prices are high, but the evidence-based medicine has to be the cultural change. The second two are items that I see we need to get out of the way on, and the one is the insurance regulation, where we have anti-market, noncompetitive regulations. Switzerland, which along with Norway, is number two or three in the world in cost, just voted to not go to a single payer entity. A market-based system works well and we need to get those anti-competitive, anti-market things out of the way, and the third is convening the state of Alaska on a multi-payer collaborative where DHSS and Medicaid and DOA and employees at the others, need to come together to use this 2.5 billion dollars leverage that is sinking our state budget.

MS. ERICKSON: Thank you, Ward. Thanks. A quick question?

COMMISSIONER URATA: No, just a comment.

MR. HOLT: Yeah (affirmative), if we can, just for -- the purpose of what we just did here, folks, was to give you a

sense of what your colleagues are thinking on the Commission. If you've been keeping your score card, you kind of have a sense of how it may line up, but also just to listen. I appreciate what Greg said. It -- this was the opportunity just to hear perspective and whatnot. What we're going to do is we're going to take our break now. It gives you a little bit of time to kind of mull this over. It's about 15 minutes, and then we're going to come back. We'll distribute the dots. We'll explain the exercise and we will vigorously watch to make sure you're following the process. So with that.....

CHAIR HURLBURT: Big brother's watching.

MR. HOLT: Yeah (affirmative).

MS. ERICKSON: Yeah (affirmative), so we'll take -- we're actually going to take our 15-minute break 15 minutes early and meet back here at 10:15.

10:01:40

(Off record)

(On record)

10:18:28

CHAIR HURLBURT: Craig, do you want to.....

MR. HOLT: Yeah (affirmative), thanks, everyone, for coming back. I guess you really didn't have an option, but thank you, anyway. A reminder of the process, this is where it really gets interesting and where we wish we had a video camera to watch this, but we don't.

Deb's going to come around now and hand you your dots. Okay, you have five. On that go around, hopefully -- the purpose of what led up to this, the homework assignment and then this discussion, was to just give you the benefit of the thinking of your colleagues on the Board, excuse me, on the Commission, as you're going through this.

We also noticed that we ask you to articulate your top one to three. You have five dots. Okay, so you have five dots. So after listening to everyone, you have five dots to affix to the different priorities.

Just so -- so what we've done now is we've had, what was on your one sheet of paper, these are now on all the flip charts, okay, behind you. So you can just walk around and look at them and they -- we actually have the strategy and then the specific priorities underneath those, so you can see how they fit, and just the only rule -- the only rule is it's only one dot per priority, so -- and some of you may be used to where you kind of free-form and you put every one -- we're changing that here.

So I'm going to restate it one more time for understanding. Only one dot per priority, but you get five dots. So that means you'll get five votes. Now, this where you get to play the, you know, the early person can set the lead. The last group of people can take it home. I mean, however you want to do this now, it's really going to be up to

you, but the other thing just as a reminder to everyone, this was to bring focus to the conversation, as we witnessed the discussion, the importance of that.

It does not mean that there will not be any other work, potentially, being done on these others, okay. This is just the focus for this Commission to say, "This is where we believe," we believe, meaning you Commission, the 14, believe you can have the best chance of having evidence, you know, some evidence-based improvement in these areas. So before we start, are there any questions on the process? Yes, sir.

MR. PUCKETT: So the colors don't mean anything?

MR. HOLT: You're not supposed to ask that question. No, it really doesn't. It.....

MS. ERICKSON: So the colors don't signify anything. One of the things I want to point out to folks, it has nothing to do with this process, but I just -- just a reminder, Barb's getting complaints over the webinar that some people can't hear you, and the importance of the mic isn't so people in the room can hear you, it's so folks on the phone can hear you, and you have to put your mouth right up to the mic and speak clearly for them to be able to hear you. So that was just another reminder when we come back for conversation.

MR. HOLT: Okay, so with that, also, just to let you know, the way we will decide kind of the cut line, we'll just look where there's logical groupings. So if we see that

there's five that seem to jump to the top, if there's three, if there's seven, we'll just collectively take a look at that when we're done. So with that, folks, let's have some fun.
10:21:43

(Board members move around the room to place votes.)
10:25:58

MR. HOLT: Okay, thank you, all. I should -- this was -- I commend you. I've done this a number of times and I commend you for the consistency in the conversation and what ended up on the board. So if you'll take a look, those that have a star, are the ones that ended up with five votes or more, basically, which seemed to be a cut line, and then there's some that -- so what I'm going to do, I don't have a portable mic. We're going to get one right now.

So I'm just stalling, but if you want to just look -- look around, you can see those and then we're just going to -- you know what, I can probably do it from here.

UNIDENTIFIED SPEAKER: (Indiscernible - too far from microphone) microphone.

MR. HOLT: Okay, yeah (affirmative), if you don't mind, yeah (affirmative), we'll go ahead and get the other mic and I'll just walk around and take a look at these. Are we live? Yeah (affirmative), okay.

So the other thing we -- and we probably should, at this juncture, this isn't a matter of also prioritizing within

these, okay. What this really is, is just a grouping that pops up. We're not trying to then say which one's the most important. We're just looking to see is there a logical grouping?

So all the green stars, there happens to be six, by the way, okay. There are six that are five or more and you'll be receiving that in your packets. It's, again, if you recall, a lot of your conversation was around prevention and it's the only strategy that had actually two priorities that popped up, of all the ones you had.

So again, your conversation found itself, actually, what you identified; so Focus on Prevention, the Adopt Opioid, and Encourage and Support Healthy Lifestyles, Build the Foundation of a Sustainable Health Care System, the Information Technology: Facilitate Telehealth, Reform Workers' Comp Laws, Investigate Transparent Legislation, and Incorporate Evidence-Based Medicine in Pay and Design Benefit and Provide Decision-Support.

A couple, just observations for you folks, it's actually a pretty nice diversity. You're -- they're not all falling under one. So this is -- this basically gives you five strategy areas that you have opportunity to move forward on, okay, so -- which is actually pretty good. So you're not all clustered in one, so that gives you the diversity of that, and also, there was -- there's only two, really, that really --

well, three that jumped really to the top, and that was on Focus on Prevention, the Opioid, the Information Technology, and then the Evidence-Based Medicine, and then there was another cohort that also jumped up right underneath that, and then there's a pretty good drop-back from that.

So it -- I just -- again, I've done this a number of times and I typically get surprised, especially with boards and whatnot, when you have the conversation and then you see what ends up on the board. So with that, let's just maybe -- observations from folks from the floor for just a few minutes and then I'll turn it back to Ward.

CHAIR HURLBURT: Bob, did you have one?

COMMISSIONER URATA: So David Cutler, in his book, "The Quality Cure," was published earlier and I think Ward has it, says, that you know, waste is a major part of cost of healthcare in America, and he lists it as billions, I forget how many billions of dollars, but the waste is divided into mistakes, unnecessary tests, paperwork, fraud, and overcharging, and the solutions that we have suggested basically sort of covers all of it.

Evidence-based medicine helps reduce mistakes, unnecessary tests, the health information technology helps reduce unnecessary tests, I mean, reproduction of tests. Administrative paperwork, as -- I'm not quite sure how to fix that, but I think with evidence-based medicine, hopefully,

there'll be less paperwork. Fraud, we need to have some other ways to fix that, and of course, transparency will help reduce over-charging, I hope, and the overlaying thing of prevention will help reduce all of that if there's less disease in the system. So I think what we're doing is great.

SENATOR COGHILL: This is Senator Coghill. The caveat that I put on the evidence-based is as long as you head to the consumer-directed part of it, if it's evidence for the provider and the payer only and the consumer is outside of the part of that discussion, so that was the only caveat. I went ahead and put my dot on the evidence-based because I think there's a great need for it, but my reluctance, as I said earlier, comes down to how do you blend those practices with consumer choices and I just -- I'm still working on that.

CHAIR HURLBURT: I would respond to that and say that is inherent in the changed and is changed, but still changing role of the physician or of the dentist or of the other provider, in that a critical part of that role now is the educator, so that the decision is made collaboratively.

You have a more informed consumer, if you have a man who may be a candidate for a TURP, a transurethral resection of the prostate, because he's getting some obstruction of his urinary stream. There are downsides to that, incontinence, impotence and so on. So you want to talk about the risks and the benefits, but I think the role of the provider, as the

expert, is to present the evidence the best he or she can, and then to have a more informed consumers make the decision on what's going to happen to their body. So I think that it is inherent in evidence-based practice and a critical part of it.

MR. HOLT: If I might real quick, also, what's happening right now, that was great, because that's what's now you're going to do with these, is you're going to take these and have that vetted conversation, but now it's focused around six, as opposed to a whole bunch, but that's precisely the next step that comes from this.

So you can get down to the further level of detail and granularity, so the intent is very clear at what you'd like to. Representative.

REPRESENTATIVE HIGGINS: Yeah (affirmative), this is Representative Pete Higgins. You know, evidence-based, for making your best decisions, you know, I've gone through this. I've gone through this route already once before and we can have all the evidence-based we want and be right on that side of the subject, but if the voters or the people that you're trying to do it, won't accept it because of an emotional argument, it's not going to happen, and what I'm talking about is the fluoride issue.

I mean, evidence-based, it's there. It's good for you, but yet, Juneau, Fairbanks, and I'm not sure about Anchorage, but we don't have fluoride in our waters because it's an

emotional argument and we can't win an emotional argument with evidence-based decision-making. So how do we do that? I mean, how do we -- I mean, I guess that's my problem and that's my frustration is that we know what's right and we know that we've got the evidence to show that it's right, but how do we get the consumers to understand that, and that's, I think, is our biggest issue with that and so I'm a little bit, you know, like I said, I went down this road once before on evidence-based. I agree with it, but how do we make it work?

MR. HOLT: If I can, Ward, again, on that, and just being mindful of the time, that's again, that kind of discussion is what you all need to kind of work through, and that's the wealth of knowledge and experience you bring to this, because arguably, you want people to look at evidence, but if they -- if it's emotional, then that's the whole discussion you all have to figure out, then what do we do, because you can't ignore the evidence and you can't ignore emotion.

Is anyone here in a significant relationship? Yeah (affirmative), right, don't take emotion out of -- yeah (affirmative), always try and have an emotional argument with facts. That works. No, I mean, it just -- it just doesn't. So I mean, that's precisely -- what you're doing right now is exactly why I wanted to have this prioritization, because then you can really have that focused conversation and not have to abandon it because you have to get onto the next strategy.

Yeah (affirmative), excellent. Ward.

CHAIR HURLBURT: Yeah (affirmative), I think what you say is reasonable, but I think you still -- you have to keep coming back with the evidence. On water fluoridation, the rest of the country is still very slowly going up, in terms of percentage of people on a public water system. It's around 74, 75%.

Alaska's unique, in that we're going the other direction. We're getting down close to half, which is unfortunate. Anchorage was one of the first cities in the country, 1953, but I would say that when the issue came up, and I'm sure it will come up again in Anchorage, there were some of the members of the Municipal Assembly, that you know, don't confuse me with the facts, but I felt like when I went and talked with them and others did, that most of them really gave you a respectful hearing and impacted on what they did, and so you win some and you lose some, and you know, at least for another year or two years or three years, we want it here, but I -- but it is an imperfect world, and you know, folks like yourself and myself and others that are trained in a discipline really are the experts and we exercise responsibility to understand the evidence as best we can and share it, but I don't know, it's kind of a touchy-feely response, but I think it's -- Larry and then David, I guess, yeah (affirmative).

MR. STINSON: For evidence-based medicine, no matter what, as we were just talking about, it doesn't matter what the topic or the proposed surgery or the procedure, I could give you evidence to do it and I could give you equal or better evidence not to do it, and then even in my clinic now, as I'm talking to one person, the other person is Googling everything that we're talking about and then coming out saying, "Well, here in "The New York Times" two weeks ago, they said that we should be doing this, and you have to patiently go through this.

There's a ton of information out there and like I said, in a perfect world, everything should be evidence-based medicine and ideally, I would love that. I don't -- the devil's in the details, as I've said before, that's -- so I think it's something to strive for. I think it's going to be more difficult to get to than what we might think.

COMMISSIONER MORGAN: I was there during this issue and the Municipality of Anchorage, primarily through my role on the Municipal Health Care and Human Resources Commission. What helped was tribal came, Southcentral, ANMC, the local medical community, the local Health Commission, which is made up of appointees and not necessarily professionals, but people interested in healthcare, plus some docs, some dentists, Dr. Kylee (sp) was one, and it took three or four meetings and sometimes it wasn't pleasant, but after a while, it did have

an effect and the issue of leaving it was dropped and of course, it will come up again in two years, but there -- sometimes it's important enough to make information available three or four times and continue to go to the meetings and monitor the meetings, especially of commissions, volunteer commissions and boards on a local, I mean, level, and sometimes, Ward's right, a lot of times you'll win it or at least, get cooler heads involved, but sometimes you lose it.

So I think it's worth the good fight, especially if it's something very evident that's pretty well agreed to as being the best evidence and that's probably the only answer I can -- I saw it in action over six months and a lot of meetings, but it did -- cooler heads and evidence did prevail after a while, but it's not easy.

MR. HOLT: Okay, we have a little bit of time and you're already doing the next exercise, which is maybe potentially identify some specific thing. I think there was a handout also. It says, "Potential Commission Activities to Facilitate Implementation of Policy-Makers." I believe you have that in your packets. It looks something like this.

What we'd like to do is we want to reclaim the time that we've got and I'm going to call an audible and I explained erroneously what that was, using a fictitious, a quarterback that had retired and was corrected by a good historian. So I will not go that way. I'll just assume everybody knows what

that is today and Deb, you might want to listen to what I'm going to say and decide if you want to do this.

There were at least three of these that had a majority of -- the largest amount of dots. So what we'd like to do is take -- I'm going to walk over to each one of these and ask for, if three Commission members -- if three Commission members could just volunteer, and we'll take about 10 minutes and have you just write out what you think would be -- this could be your template to look at, but write out under, for instance, Adopt Opioid Control Policies & Programs, have you just write down very specific things you think you could do, and I'll go through those and we'll go -- because if we take those three, that will give us four or five members per and then we could end up with as many as four or five potential topics. Deb.

MS. ERICKSON: In addition to opioids, what were the other two? I'm not -- I haven't counted.

MR. HOLT: It was Incorporate Evidence-Based Medicine, we're on that one, and then Health Information Technology Facilitation.

MS. ERICKSON: And that was specific to telehealth, yeah (affirmative), thank you.

MR. HOLT: Yeah (affirmative), telehealth. So I'm going to go mobile. I should be on -- yeah (affirmative), so the three -- and then I'm just going to -- if you could, just --

if you could, as a Commissioner, just pick one of these that you feel, you know, strongly about, and then we'll have the five of you jump on them.

The three, again, are Adopt Opioid Control Policies & Programs, the telehealth, and then what we were just having a lively discussion on was incorporating evidence-based pay. So who would like to -- and what you're going to do is take about 10 minutes and just write out some very specific action steps you think that could be taken.

COMMISSIONER URATA: Can we do it together as a group? Do we get together.....

MR. HOLT: That's a great idea.

COMMISSIONER URATA: And then just.....

MR. HOLT: That's a great idea.

COMMISSIONER URATA: Like we did yesterday with (indiscernible - too far from microphone).

MR. HOLT: I can't split my fee with you, but that is a good idea. That is a very good idea. So let's do that, okay. That's what we'll do. So which five would like to jump on Adopt Opioid Control Policies & Programs? Go ahead, get your hands up, so we see who you want to -- one, two, three. We need two more, four, five, thanks, Becky. Okay, you're one group, all right. Where was the other one?

UNIDENTIFIED SPEAKER: Technology.

MR. HOLT: Thank you. Technology, telehealth, we need a

few more, two, we need a couple more. Thank you, Senator, and then Lincoln, and then right here, and then Emily, so you four, okay, you five. So that means whoever is left, let's see if we should have about five hands now. So who's left on evidence-based? One, two, three, okay, we'll just go with that. If you can go ahead and just -- go ahead, Ward.

CHAIR HURLBURT: We have 13 out of the 14 Commission members here, because Keith Campbell is off (indiscernible - speaking simultaneously).

MR. HOLT: Thank you. My engineering degree didn't work on that one for doing the math. So let's have one from the telehealth jump, thank you, and you can jump -- thank you very much, into Incorporate Evidence-Based Medicine. So let's have the Evidence-Based Medicine folks here. We'll have the Telehealth right by Susan, and then the Opioids, who was leading that one? Is there someone -- who was on that one? Becky, okay, then let's come here, okay, opiates on this end, all right, and just get together about 10 minutes, list out what you think they are and we'll go from there.

10:44:05

(Off record)

(On record)

10:46:16

MR. HOLT: If I can real quick, just as a point of clarification, I'm hearing a couple of comments, what -- this

is specific action the Commission would take to effect this moving forward, not others would do, but specific action the Commission would take going forward, okay? So I just want to make sure. I wasn't quite clear on that. Thank you.

10:46:32

(Off record)

(On record)

10:50:49

MS. ERICKSON: Can I offer another clarification, too, to our three workgroups, David? Folks, remember that you -- we're going to be taking action to implement our existing recommendations. We're not changing or adding to our policy recommendations.

So it might be helpful if you are looking at the policy recommendations as you come up with ideas for facilitating implementation, but this needs to be an action that the Commission can take.

10:51:51

(Off record)

(On record)

11:10:45

MR. HOLT: So Commission members, if you could go ahead and reseat yourselves and then we'll just do a quick report out of just activity. Okay, as we're assembling here and finding our respective places, the challenge of that exercise

was two-fold, 1) to move it from a policy down to a specific, you know, actionable thing that could be done, and the other caveat was by this Commission, and so those are two kinds of tough constraints to kind of wrap your head around and I think we -- and we put you in nonhomogeneous groups, very random, and just watching the discussions, they were very unique to each group. I'll just leave it at that and -- and so -- and we gave you about 15 minutes.

So all of that, as a caveat to those that aren't in the room that are watching this or listening to this, this was just to begin the process of what it's going to look like to actually drive out very specific things that the Commission can do that are unique, and I will say, listening to some of the conversations, that's why there are so many of you here with such breadth of experience because you can very quickly, I think someone said in one of the groups, "We're the real-time database to figure this out." I thought that was a great statement, because you can quickly, at least triage out, the stuff that didn't work.

As someone said, "Then what remains, no matter how improbable, is still possible." Anyone watch Star Trek? Okay, yeah (affirmative), I actually -- did I get that one right? I think I did, right, okay.

So with that, let's start with the Telehealth and then we'll do Evidence, and then -- excuse me, then we'll hear from

the Evidence, and the last group is the Opioids. So if you -- whoever -- who was on that -- yeah (affirmative), if you want to just mention who was on that with you and then your partners in crime will go around.

COMMISSIONER YEAGER: Okay, partners in crime, Lincoln Bean was a partner in crime, Senator Coghill, and Greg Loudon, was our -- did I get everybody, and myself, I was there, too. So we did have a lot of really good brainstorming. It seemed like the time went by in a flash, not enough time to really capture things in a very coherent manner.

However, what we came up with is that what the Commission could do is in support of this priority is to convene some type of conference with the appropriate stakeholders to evaluate the current state of telemedicine in Alaska and to look at how to expand, leverage that into covering multiple beneficiary groups, evaluating things, such as the technology, which could be, you know, looking at interoperability, bandwidth, looking at hardware/software issues, looking at the business relationships that would need to be in place, and that includes things, such as credentials and improving licensure issues, looking payers, what -- how would the -- what would the payer system look like to incentivize and support a telemedicine system statewide, looking at the legislation, what legislation is there that would currently support the expansion of this tool for access to high quality

healthcare or legislation that may be needed that -- to encourage the growth.

There may be something legislation-wise that is currently a barrier to, you know, exporting what's going on now and making a coordinated system statewide. Let's see.....

MR. HOLT: Let me interject for a moment here.

COMMISSIONER YEAGER: Okay.

MR. HOLT: This wasn't a set up, but if you look at what's up here, this is a really good example of one, because you clearly could show whether you affected this, correct, because it's about identifying ways to leverage the telemedicine in Alaska. This is very measurable.

You will be able to see, you know, and this is just how many shared networks out there, how many -- so this is one you literally -- you could show on this. So I'm just giving this one as an example of, not that -- but there happens to be a Senator in that group or anything, but the fact is that this actually happens to be a really good example, as you're thinking about going forward.

It's something very actionable that is measurable, that if it were not for the Health Care Commission calling this together, it may not have happened. Does that make sense? Those are the kinds of things that we're looking for. Continue, please.

COMMISSIONER YEAGER: And we just also felt another piece

of that would be looking at training, education, implications of this new way of doing business, new way of treating folks, and with a goal of having -- coming out with a plan on how to maximize the use of this tool, taking into consideration, all of those different areas. I think that's -- in a nutshell.

REPRESENTATIVE HIGGINS: I have a question, is that okay?

MR. HOLT: Yes.

REPRESENTATIVE HIGGINS: I don't mean -- and because -- well, I'm new to the Commission, so I guess I maybe don't understand where -- how much money you guys have, because when you say I want to convene a conference, well, who's going to pay for that conference? Does the Commission pay for that conference? Does the state pay for that conference? How do you convene a conference to do that, to begin with, and then who are you convening the conference for? I mean, that's -- and those are -- maybe those are questions that -- I don't know.

MR. HOLT: Let me -- yeah (affirmative), as you go through this, it's a series of gates that you go through, and the first is, let's get the ideas up there, and then represent -- then vet those out on those kinds of -- those are the kinds of things you look at going forward from -- because some of them may be expensive, some may not, some you might get sponsorship, but when you're just getting these together and trying to kind of brainstorm ideas, I really encourage bodies

like this not to -- unless it's an obvious, it's going to cost us a million bucks and we can't do it, does that make sense to folks?

Okay, as you're -- so as you really start going forward and vetting these out, you know, what is the cost and then -- but there's lots of creative ways to get at money in doing some of things kinds of things. Okay, who -- was that it from your group?

COMMISSIONER YEAGER: I think that was pretty much it.

MR. HOLT: Okay, thank you, for a short period of time. Who was next? Evidence, yeah (affirmative).

COMMISSIONER ENNIS: I can start. Remarkably, there were already quite a few activities recommended in our handout for proceeding with evidence-based medicine and how to both encourage and implement the use of this information, and -- but I'll just generalize what they already specified as recommendations, and one was, of course, to make sure that we have both information about evidence-based medicine and how to access the national websites that are currently available to obtain more information in terms of diagnosis and what's called order sets, how to treat specific diagnoses.

So making sure that our medical practitioners and our insurers and other healthcare professionals are well aware that there is information currently available.

The second is early training for healthcare professionals

when they're in their early educational stages, particularly the WAMI program and our nursing programs in Alaska to make sure that, again, they have all the basic information for use and access of evidence-based medicine, and thirdly, looking at how to both get this information and encourage use by established healthcare professionals and providers, and I know that Jim has some additional details. Perhaps, he -- you'd like to reference in terms of what's already been recommended.

MR. PUCKETT: We wanted to take the -- one of the recommendations that was offered on the handout, number one, and we were going to combine number one with, this is when it gets confusing now, number two on the second page. They're both very related.

One is for the decision-making part and the other one is for the education part, but we saw that we could combine those two to make one recommendation. I'm just waiting until Deb -- to catch up with typing out number one and then I'll tell her what to type for the other one.

COMMISSIONER STINSON: What page are you on, Jim?

MR. PUCKETT: Okay, we took number one on page one, convene state agency leaders to facilitate mutual learning sessions, et cetera, and we were going to add the word, and, at the end of that recommendation, and then in number two on page two, it begins, "If the SOA as purchaser," we're not going to use that part. We're going to go further into it to

the word begin, begin a series of annual seminars for State of Alaska Staff. We want to add SOA, to facilitate understanding of and expertise regarding evidence-based medicine.

We also felt that number five and number six on that first page were very worthwhile actions that the Commission could do. The other things I'm going to offer, Deb, we don't need typed out. I'll just share this information to share with the Commission.

Those of us in the evidence group, we looked at number one on page two, convene clinician training programs, et cetera, we felt that one, six and seven from that section would be something that the Commission would consider sharing with the WAMI program, University of Alaska, to begin getting the information out to the stakeholders that would need to provide training or would provide training and education for all of these healthcare people that are going to need to learn how to use evidence-based information.

MS. ERICKSON: I just added that to the second bullet from Emily related to provide early training, that we -- the Commission could.....

MR. PUCKETT: Okay.

MS. ERICKSON: .....actually collaborate with WAMI program leaders and maybe have a session or a forum with them to talk about what they're already doing, because that's something that we've had conversations around this

recommendation with. Leaders in that program have been working on curriculum reform for medical students, but we could continue that conversation.

MR. PUCKETT: And I think we gave you enough.

MR. HOLT: So again, as you look at this, just for as you're looking at what type of objective you'd be doing, the first one is fairly broad and I think Emily mentioned that it was fairly broad. The other ones, they're very specific. They're measurable. You can see how they contribute directly to the ensuring evidence.

So as you think about putting these together, they really continually need to get down to, if you've done planning in the past, it's down to the objective and tactic level now, and something, again, that the -- so those -- the second, third, fourth, fifth, and sixth bullets, all look like, you know, very viable things that the Commission could do.

The first one is pretty broad and might take a little more -- and I know we gave you, what, 13-and-a-half minutes to do this, so just coaching as we go forward. So our -- the other working group that we had was opiates and so let's jump to that one and who wants to speak for that group?

COMMISSIONER HIPPLER: This is Allen Hippler. I'll speak for that group. The group consisted of Representative Higgins, Becky Hultberg, David Morgan, Dr. Larry Stinson, and myself. We came up with -- we came up with two things. First

is in reference to real-time databases, the Commission could sponsor research to determine cost savings to the state portion of Medicaid expenses related to a real-time database.

The second is the Commission could convene a meeting with key legislators to discuss said real-time database. I will now defer to any members of my team to elaborate or add. Thank you.

MR. HOLT: Yeah (affirmative), go ahead.

COMMISSIONER MORGAN: Yeah (affirmative), I'd like to add one thing. The last time this bill came up, I was in Juneau. I think there will be a bill. There was in the last session and I think it's incumbent upon the members of the Commission that support this to testify or to let their views known with the legislative committees involved in the review that we support it and why, and to help get through -- just like on the evidence-based issues in general, get through the clatter of interest groups and talk about this and what the real good is, and you don't have to go to Juneau. You can get on the list and you can call in, but we need to show some skin in the game on this, I think.

REPRESENTATIVE HIGGINS: You know, as the discussion on this went on, this is Pete Higgins, Representative Higgins, and the discussion was, you know, we all understand the real-time database is important. The problem is it's a fiscal issue, as legislators look at it.

So what we have to do is make this a priority issue and not a fiscal issue for the state and how do we do that, and that's what we try to, you know, bring the stakeholders together so that we can talk to our key legislators about that, and try not to make it a fiscal issue, but -- because it is, but make it an importance and we're willing to pay for it, no matter what the cost is. That's how important it is, so I mean, that was kind of some of our topic discussion.

COMMISSIONER HULTBERG: Just one more thing to add, the other issue we talked about were -- we touched on just briefly were prescribing guidelines. We specifically talked more about emergency department, but I think one role that we -- was not -- that we just touched on was potentially the Commission serving in a convening role regarding prescribing guidelines.

MR. HOLT: And also, Deb, if you could capture the, at least the statement, I'm not sure if there's necessarily an action yet, but the statement about changing this discussion to a priority versus a cost. Is that what you said, Representative, yeah (affirmative), because the group had quite a discussion about that and so if you could hit another bullet about reposition conversation around prevention to prioritization, as a priority, or someone that was in that group, I didn't hear the totality of that.

MS. ERICKSON: I don't know what that means.

COMMISSIONER HULTBERG: What we were talking about is when you're having a discussion, that it's not always -- that it's dollars and stories that move public opinion. It's not one or the other and so we need to find a way to express both dollar savings from taking this action, but combine that with story-telling.

MS. ERICKSON: So could one of the -- the actual, specific action step of the Commission be to gather stories to add to the -- I mean, we already -- we have a series of findings and I already gathered a bunch of data on the problem, so we have the data, so.....

MR. HOLT: It's the proactive.....

MS. ERICKSON: So it's.....

MR. HOLT: It's the proactive part of.....

MS. ERICKSON: Gather stories to accompany the data to share with legislators and policy leaders?

MR. HOLT: Yes. Yes.

CHAIR HURLBURT: Did you address access to the database, because a more real-time database will cost significantly more than the one that we have now, but if you don't allow access to, for example, the pharmacists with the Medicaid program, we probably won't be a whole lot better off.

MS. ERICKSON: Yeah (affirmative), we'll actually talk about that this afternoon under our -- because that came up in our fraud and abuse discussions and is one of the draft

recommendations right now.

MR. HOLT: I think maybe just for a placeholder, Deb, because this isn't final, but it's, yeah (affirmative), gather stories -- yes, that's it. There you go.

COMMISSIONER YEAGER: This is Susan. Just wondering, too, were you talking about the idea of explaining or communicating the public health implications and the quality of life and the safety issue related to opiate use?

COMMISSIONER HULTBERG: Yes, I think we didn't get into that level of detail of discussion, actually, but yeah (affirmative), it was really to just -- to talk about the -- to put a human face to the opioid crisis.

COMMISSIONER MORGAN: I know that Doc had -- was texting some people on his phone and getting information. I texted just when we started our -- a couple of pharmacy directors and I'm now still getting stories of people, pharmacy shopping and OD-ing, and so I mean, I don't think that will be that tough. We just have to make sure that somebody takes it and shares it with these guys so that they can hear it, I think.

MR. HOLT: Yeah (affirmative), just go. We're free-forming now. So whoever gets their mic lit, gets to go.

COMMISSIONER STINSON: One of the people who was intimately involved with getting legislature -- legislation passed in Washington state that's led to significant improvements in a variety of things having to do with opioid

administration, ER visits, et cetera, said he would be available to either come up or even testify over the phone if we ever wanted him to with some current information as to the kind of human and otherwise dollar savings that they have benefitted from.

COMMISSIONER HIPPLER: So we did talk a little bit about stories, but we didn't get that deep into stories and I -- I didn't know that it would on the screen here. I feel like giving stories to legislators is almost playing dirty, when you give them the, you know, the sob story about here's what can possibly go wrong and here's what's happened to this 16-year-old girl and I'm sure those stories happen, but stories are also drivers of really bad law, because you get emotion in there and emotion and exceptional cases drive very bad law. So I hate the idea of the Commission gathering emotional stories. I feel like we should be much more sterile than that.

MR. HOLT: Well, and that's why there's 14 of you, is that you're going to have different perspectives, and you know, it's not final until, you know, a motion is made and things are finalized.

It's amazing that there's that many up there for the conversation they were having, because just being very candid, but I think what it shows -- I think what it shows is.....

UNIDENTIFIED SPEAKER: (Indiscernible - too far from

microphone).

MR. HOLT: You're right, yeah (affirmative). We were told to leave the room. Maybe that's what happened is the good work came out, but you can see the advantages in a process like this when you just get started and then use the whole group and you can -- and you pull it -- I want to say -- echo something Dave said and it may have been almost a throw-away, but these don't have to hard to be impactful.

They don't have to be hard. You just have to be very clear on what you want to do and then just assign them and go do some of them. So with that, thank you, folks. I mean, this was great kind of brain -- go ahead, Becky or.....

COMMISSIONER HULTBERG: No, it's Greg. I just wanted (indiscernible - too far from microphone).

MR. HOLT: Greg, go ahead, sorry.

COMMISSIONER LOUDON: Yeah (affirmative), I just had a question really about process and it's something that came up in our group and I hear it in a couple of others, too, specifically on the opioid, we talk about the Medicaid related expenses for this real-time database. That's only one small segment of our state and our healthcare spend.

The question that came up for us talking about telemedicine was, I think Senator Coghill and I both had looked at the mission of this Commission is to affect healthcare for all Alaskans, not just the state of Alaska, and

so I was really -- when I was evaluating all of our policy things beforehand, I was looking at that, about the impact it would have across the entire state, rather than one segment.

So even evidence-based medicine, I'm a huge believer in evidence-based medicine. I like it. I just wasn't sure that we could impact things when we have, you know, disparate, small groups of providers across the state. So that's maybe a comment and a question, is that how are we evaluating this, the process? Are we looking to impact healthcare for the state, for all of our people or for just the state of Alaska.

MS. ERICKSON: Well, I was just going to say that to the extent that our recommendations are focused on state government policy, in some cases, we identified areas where we could change laws and address other practices generally, that would cut across the whole system, but in other cases, we identified where the state could provide some leadership through making changes in their own programs and leveraging change where the state spends 25% of all dollars for healthcare in this state, how could changing state practice more directly through the dollars that are spent for healthcare through the Department of Administration and the Medicaid program, leverage that change to drive change overall in the system. So that's why there ends up being a little bit of a blend. Go ahead.

COMMISSIONER HULTBERG: And just a point of

clarification, the reference to Medicaid we were talking about, which I don't think we explained well, is the prescription drug database got -- was -- is -- was funded only because the department found money to fund it this year.

It was not funded through the appropriation process and so it -- the sustainability of that database depends on ongoing funding. So the Medicaid reference was simply to show that if we -- if we put practices in place that reduced opioid prescriptions in the Medicaid program, what would those savings be, and could that offset some of the cost of the database itself. So it was not to impact the rest of the state, but just simply to try to demonstrate a cost savings to offset the ongoing operating costs of the database.

MS. ERICKSON: We are out of time, but yeah (affirmative), so we're actually, we were ahead of schedule for a while. Now, we're about six minutes behind, but that's okay. We need to break for lunch and we were supposed to have our lunches here, Barb, weren't we? Are they not here? I don't think -- we'll find our lunches. I'm afraid we -- for those of you who got to be with us yesterday, we spent too much money feeding our elders yesterday, so we're having a cheap box lunch today, and we're going to reconvene at noon, but before we break, we have one important thing we need to do.

If you guys will pay attention, please? I shouldn't have

talked about lunch before I told you your work was done, but we need to move quickly, because we're only going to have about -- David, David, David -- we're only going to have about 20 minutes for lunch, and we can talk over lunch for a few minutes and follow up this conversation, but I think, Dr. Hurlburt, what we wanted to do, and this was for the purpose of going out for public comment, what we'll include in our draft release in November is that the Commission has selected these top six items to work on active implementation around over the next year, at least, and so do you want to entertain a motion?

CHAIR HURLBURT: Yeah (affirmative), do we have -- can we have a motion to do what Deb just said, to identify these.....

DR. URATA: So moved.

CHAIR HURLBURT: .....items with the stars to go out for public comment?

COMMISSIONER LOUDON: Second.

CHAIR HURLBURT: Okay, it's been moved and seconded. All in favor say, "Aye."

ALL: Aye.

CHAIR HURLBURT: All opposed? Okay, it's passed. Thank you very much. So we will break. Barb, any word on lunch? Is it outside?

MS. HENDRIX: I just (indiscernible - too far from microphone), but they're not out there, unless you want to go

(indiscernible - too far from microphone).

MR. HOLT: Well, there's a lot of.....

CHAIR HURLBURT: (Indiscernible - speaking simultaneously).

MR. HOLT: .....butter and rolls back there, if people are interested, so.....

MS. ERICKSON: Well, we're only going to have a break for 20 minutes, because we're going to reconvene right at noon for public testimony and then we have panels starting at 12:30.

UNIDENTIFIED SPEAKER: Could we start public testimony right now?

MS. ERICKSON: We advertised it at starting at noon.

CHAIR HURLBURT: Yeah (affirmative), that's probably our tightest timeframe that we have. Okay, so anyway, the lunch comes, there should be enough lunch for everybody. If the Commission members could get theirs first, and then we will tie into the public comment period at 12:00 sharp, but there should be enough lunch for everybody in the room. I believe, unless we saved more money.

MS. ERICKSON: If we run a little short this time for boxed lunches, we actually have plenty for everybody in the room. I wanted to save a couple for our panelists, who might show up early.

11:40:05

(Off record)

(On record)

12:07:26

CHAIR HURLBURT: I'm a little over and I apologize to anybody on the phone. We have just one individual, I believe, signed up here. This is our public comment period that we have at each of our meetings and initially, we take public comment from those who are here in attendance and then I'll open it up to anybody that's online, and Tom Obermeyer, I think you're the -- I believe the only one that signed up. So if you'll come up to the table and identify yourself and if you represent anybody, and then we appreciate hearing what you have to say, Tom.

MR. OBERMEYER: Okay, I guess I'm on. Good afternoon, I'm Tom Obermeyer, former legislative assistant to Senator Bettye Davis, who was the Chair of Senate Health and Social Services Committee for a number of years, and I've been watching the Health Care Commission and the progress of healthcare in Alaska for a number of years.

I have children in healthcare and I do have some concerns that may not be on the high part of your program today, but the federally managed health insurance exchange under ObamaCare and the effect of the decision not to participate in the state Medicaid expansion, I don't know if you all heard the public radio program yesterday on ObamaCare, it's first year, how did it go, because yesterday, October 1st, was

supposed to have been the roll out of the one-year anniversary of ObamaCare.

It was indicated that 7.3 million were brought on insurance last year. Bob Laszewski of Health Policy Strategy Associates stated, as one of their main contributors, that 10 to 11 million are now insured who were not insured before. Most gains were in the Medicaid expansion in 27 states and D.C. under ObamaCare. The rest were through state and federal exchanges, and I noted that Alaska did not participate in Medicaid expansion and didn't establish the state health insurance program exchange. So Alaska still has thousands uninsured.

Jonathan Gruber, and MIT economist, who helped design the Affordable Care Act and similar Massachusetts law, also commented. He said the most important factor is cost. Before ACA, cost of individual insurance was rising 10% or more per year. This year, he said they don't expect much at all in increased costs on the individual insurance, but again, I note that by contrast, Alaska has announced an approval -- an approval of 37% increase for Premera next year, Moda Health, 22 to 29%, and Moda Health has announced it's cancelling individual coverage in 2015 for policies that do not meet certain criteria. This is contrary, as I understand, to the intent of the federal government's three-year safety net.

Mr. Laszewski indicated that the current government

program protects insurance companies for the first three years in the marketplace, even if their motive for quoting lower prices was to gain market share. Now, I don't know if that applies to the situation in Alaska, but it would certainly seem that our insurers could stay in the market if they're being guaranteed by the government.

Caroline Pearson, consultant to Avalere Health, said that many insurers are flying blind without full knowledge of costs. Gruber says it will take two to three years to determine if the Affordable Care Act is a success or sustainable or too high priced. He said exchanges need seven million new enrollees the next two years to meet critical mass in order to succeed.

Gruber said it's not the total number enrolled that's important, but whether the premiums are affordable and if premiums are too high, individuals are priced out of the market. Gruber is also worried about what Congress and the courts are doing. I note that they're -- I note a decision by a U.S. Court of Appeals that's -- that may actually gut the Affordable Care Act.

I note, Alaska apparently has enrolled far too few individuals to make the federal exchange profitable. That's my comment, that Premera reports losing seven million this year on 33 members. This is in the Alaska dispatch. It also forecasts a loss of five million next year, even with a 37%

increase and reporting that it needs, really, a 71% increase to break even next year.

Marilyn Tavenner, the administrator of Centers for Medicare and Medicaid Services, who also runs Health Care Reported on NPR yesterday, insurers are getting cost information, evidenced by the 7.3 million signed up by August this year, but needed, is a financial management package for insurers that is more important to insurers than consumers signing up.

The Affordable Care Act is still a work in progress, she admits, with technology improvements greatly helping this year. Tavenner expects new enrollee outreach from secondary markets next year like Charlotte and Raleigh. Penalties for no insurance will increase to 325 next year or 2% taxable income of $1,500 on a $75,000 income.

The government is seeing less churning, they say, by consumers this year, but next year, Tavenner says will be -- there will be more choice. The government expects a 25% increase in issuers and fewer uninsured.

I note that this is the reverse of the experience in Alaska, which has had only two insurers, Premera and Moda Health this year, dropping to one next year in the individual market. Senator Begich suggested in the Alaska dispatch the other day that maybe a copper plan for lower income Alaskans would work and the department reportedly is looking into it.

Now, there is a decision in the Court of Appeals. Jacquelyn Halbig, former Senior Policy Advisor to Health and Social Services under President George Bush, won a decision in July, but it was vacated and we reheard it in December, where Halbig challenged the power of the federal government to spend money on subsidies for policies that were purchased at the federal exchange.

Halbig claimed that the text of the Affordable Care Act allows subsidies only for exchanged and "established by states under Section 13.11." Federal exchanges are established under 13.21 of the act. Subsidies for citizens in 31 states, it reports, are at risk because people in those states signed up under the federal exchange, including Alaska.

As a dissenting senior judge, and this is going to be heard again in December, on the first appeal, Edwards wrote, "This case is about the appellants not so veiled attempt to gut the Patient Protection and Affordable Care Act. At time of the Affordable Care Act's enactment, it was well understood that without the subsidies, the individual mandate was not viable as a mechanism for creating a stable insurance market."

So all this brought me to the following questions, and I'll run through them very quickly, and of course, you all have copies, how can Alaska Department of Insurance or Division of Insurance provide access to health insurance for all citizens under the Affordable Care Act if too few

consumers participate and too few insurers are in the market to make the exchange sustainable in Alaska?

What are Moda Health individual policyholders to do who are cancelled at the end of the year? What happened to the idea to combine with other states to offer a comprehensive state health insurance exchange? How can the approved and proposed huge premium increases in Premera and Moda Health do anything, but kill the individual insurance program here?

Why are huge premium increases allowed by the Division of Insurance, if the federal government reportedly provides a reimbursement safety net for three years while the program gets underway? How many more Alaskans would be insured if Governor Parnell had approved Medicaid expansion? How many more millions of dollars would have been provided by the federal government and what would the state's share have been.

How much of the cost of Alaska's uninsured was shifted to hospitals Medicare -- a disproportionate share of hospital adjustment amended under the Section 1886 of the Affordable Care Act. Payments for uncompensated care was increased under Section 3133 of the Act. So it looks like it's going in one pocket and out the other, but they're not -- might not be a net savings to the federal government.

Commissioner Streur reportedly explained on Alaska Public Radio the other day that the state's effort to curtail Alaska's increasing share of Medicaid cost is due to the fact

that Alaska has the highest per capita healthcare cost in the nation, and in fact, I think he said it in the world, for that matter.

While this view may recognize increased cost due to our diverse and dispersed population over a vast geographic area, how can we justify eliminating the state's share of Medicaid costs if it does not reduce the federal government's cost of care overall in the state? If we are simply shifting payments from Medicaid, basic Medicaid to DHSS payments under the Affordable Care Act, are we not forcing uninsured Alaskans into more costly emergency rooms or leaving them at risk of little or no care at all?

So those are really my observations on what's going on in the market. I'm sure you people have a lot more information but these were concerns that have come to my attention over the last several months and I don't see an awful lot of help coming, when it comes to any implementation in this state of the Affordable Care Act. It seems like it's been a losing proposition from the get-go, as at least to the individuals in the market, and maybe the plan is working fine in the group market and that's probably -- maybe one of the reasons it's continuing with the intended increases that have been proposed.

CHAIR HURLBURT: Thank you very much. As you indicated when you started, the Health Care Commission has not really

been the entity dealing with these issues, but we have tried diligently to keep ourselves informed on this and your analysis here is helpful. Obviously, it's a work in progress with another decision out of Oklahoma yesterday, but thank you for bringing these issues to us, Tom.

MR. OBERMEYER: Well, thank you for the time. I appreciate it. It's nice seeing you all again.

CHAIR HURLBURT: Good to see you. Was there anybody else in the room that wanted to testify? I didn't -- nobody else had signed up. Online, do we have anybody that would like to testify? Anybody that's online, we appreciate you calling in. We didn't hear back from anybody. So we will end the time of public testimony. Please, yeah (affirmative).

MS. ERICKSON: I think I'll suggest that we just break for another five to 10 minutes. We have at least three of our six panelists for the next session here. Our next session is scheduled to start at 12:30. For those of you in the room and also for Commission members, if you didn't have a chance, the final version of the ICER Summary Report of the Employer Survey was in the extra packet that was at your seat this morning.

I had included in your pre-meeting notebook, a draft of that. So you might want to just spend a few minutes right now, reviewing the four-page summary report. For those of you in the room, there's a copy of it out on the back table or the

table outside with the handouts, but our next panel is going to be a panel of kind of employers and business sector representatives commenting on the findings of that study that the Commission paid for, employer health benefits. So we will get started again in five to 10 minutes. It should be behind Tab 3, but again, in your notebook, that was the -- yeah (affirmative), you got it. You got it, and for the folks in the room who are on the panel, whenever you're comfortable and ready to come sit up at the table, you are welcome. We'll get started again in about 10 minutes, right at 12:30.

12:20:39

(Off record)

(On record)

12:30:38

MS. ERICKSON: If the Commission members could come back to the table, we're going to get started. Is Gunnar here? Gunnar, come sit with us, please. There's a chair over there. I think the only panelist we're missing is Thomas, but we might start without him. So we're going to get started in just about 30 seconds, I think.

Bill, do you want to move around next to Mark, so we can see you, the folks on this side of the table can see you? Thank you.

CHAIR HURLBURT: Okay, we'll go ahead and move onto the next session. I think you'll find it very interesting. As

you've known, as Deb and I have shared with you, we've had some opportunity to work with folks in the business community here that are facing the challenges on the kinds of issues that we've been talking about, the challenges that the state, as an employer and as a payer, is facing and they've been engaged in that in their day-to-day work. We've shared information. They've been great supporters and have provided a lot of help for us here.

So the panel that we're going to have for the next hour, will be to look at the survey that was done for us and we have Dr. Guettabi and Gunnar Knapp, Dr. Gunnar Knapp here with us at the front table, who did the survey, taking the information and as Deb said right before lunch, you have the final copy that was there for us, and so we have our panel.

We have Todd Allen here, who is the Vice-President for Human Resources for Carlile Transportation Systems, and I'll let you go through the list first, Tom Showalter, HR Director, Ukpeagvik Inupiat Corporation, Florian Borowski, HR Director, CH2M Hill, Rick Harwell, HR Director, Doyon Universal Services, Bill Popp, President & CEO of the Anchorage Economic Development Corporation, and Mark Foster, who -- the members of the Commission who've been here for a while know Mark because he's been kind of a semi-regular visitor and has done work for us and participated with us and has been a great resource with us here.

So what we want to do is have each of the panel members, maybe just introduce yourselves and talk a little bit about what you have been engaged in. The hat that Mark has on now, initially, it wasn't as a health economist and providing information, but as the CFO with the Anchorage School District is now very much where the rubber meets the road of where do you get the money to pay for these 18%-a-year increase in costs in healthcare that are keeping us from giving salary increases to teachers and whatnot, and we'll hear that.

So each of these folks will represent the business community and if you can just say a few words first, about what you've been doing and then we will have the questions that we'll pose and talk about and have the authors of the document here be able to respond to questions we may have. So Todd, if you could go ahead first, please? Go ahead.

MS. ERICKSON: We're going to -- yeah (affirmative), that's okay. We have folks on the phone and we are webinaring our meeting and so you need to turn on the mic and speak directly into the mic, even though we'll be able to hear you fine in the room. We need the folks on the phone to be able to hear. Thanks.

MR. ALLEN: Okay, do I have to behave, too?

MS. ERICKSON: Well, yes, for the next hour.

MR. ALLEN: Okay, all right, okay. Well, my name is Todd Allen. I'm the Vice-President of Human Resources for Carlile

Transportation. Just a little bit of background, I've been up here in Alaska since the mid-80's. I came up originally with British Petroleum. Some of you may remember, it's the old Sohio days, and I've been here for -- in and out a couple of times, but I've been with different organizations, Koniag. I've been with ASRC Energy Services, also with Wells Fargo at some period of time.

So right now, I've been with the Carlile Transportation and now, are you wanting me to address like the first question or do you want to go around the table to interview -- to introduce folks, first?

CHAIR HURLBURT: No, if you could go ahead and also comment what you're doing, and I think we would be particularly interested, and I know we probably didn't warn you in advance, but if you could maybe say a little bit about what Carlile has done with the clinic there at Alaska Regional, the H2U Clinic, the collaboration with the Hospital Corporation of America, with the nurse practitioners there that you were the pioneers on and we have some of the union trusts are doing it now. The state has looked at doing a similar kind of thing and others, but I think you're going to have some unique experience in the room, and maybe if you could say a little bit about that.

MS. ERICKSON: Ward, just a process.....

CHAIR HURLBURT: Okay.

MS. ERICKSON: We actually have that question on the three questions that we're posing to them for the discussion.

CHAIR HURLBURT: Okay.

MS. ERICKSON: So just processing, that's part of our second question. He would be answering that and we could ask for clarification then.

MR. ALLEN: Okay, so my -- so my -- so.....

MS. ERICKSON: So should -- did we want to just have them introduce themselves real quickly and then go to the first question or do you want to just start with the first question?

CHAIR HURLBURT: That sounds fine. That's fine. So why don't you just go ahead, Tom, we'll start next with you to introduce yourself.

MR. ALLEN: Do you want me to continue the -- or answer the question, I'll just.....

CHAIR HURLBURT: Why don't you wait?

MR. ALLEN: Okay, I'll just wait and back off.

CHAIR HURLBURT: No, I threw us off course there.

MR. HARWELL: My name's Rick Harwell. I work at HR Doyon Universal Services. We represent about 1,200 employees throughout Alaska, Texas, and Washington, and we're, obviously, owned by Doyon Limited and then a large company out of France, Sodexo, with -- it has about 400,000 employees, and we actually get our health benefits through Sodexo because of their large buying power.

MR. BOROWSKI: Well, good morning -- afternoon. Florian Borowski, I'm the Director of Human Resources for CH2M Hill Alaska. We have 2,400 employees here in the state of Alaska. That makes us the eighth largest employer. I am also the Vice-Chair of the Alaska Workforce Investment Board and am really pleased to talk to you today, and also, frankly, very pleased that the legislative body was able to recommission the necessary funds for you all to continue this important piece of work and we'll talk more about why we think, as private industry, this piece of work that you're progressing is so important.

MR. FOSTER: Mark Foster, currently the CFO at Anchorage School District, previously a consultant with ICER on a number of healthcare studies, including an assessment of the Affordable Care Act and its implications for Alaska back when it was in development and then when it passed. So it's been very interesting to watch the unfolding.

MR. POPP: I'm Bill Popp, President and CEO of the Anchorage Economic Development Corporation. We are a 501(c)(6) membership organization. About 82% of our funding comes from private sources. So we're not a government agency. Although, we do have some government support. We represent 258 businesses in Anchorage and across the state of Alaska, and we are very focused on the issues of the high cost of doing business in the state on a number of different issues,

healthcare being one of them.

CHAIR HURLBURT: So we can probably just go down the list, maybe, and give you each a chance to speak to these issues. You've seen the survey. Todd, if we can come back to you and go ahead and start with you again, then?

MR. ALLEN: I didn't even press the button, too. I didn't know how to do that. Yeah (affirmative), thanks, guys. As you.....

UNIDENTIFIED SPEAKER: Teamwork.

MR. ALLEN: Teamwork, I'm glad you're sitting around me here. Well, the first question is -- or your initial reaction to the summary. I didn't find anything -- I didn't -- I didn't see anything that surprised me at all. I typically find that -- and I've been in this -- in the role for a number of years in different capacities and I see, typically, the healthcare costs about 30% higher here in Alaska than they are elsewhere and typically, just say the Lower 48.

Do the -- the question, do the findings reflect your company's constituent experience? Right now at Carlile, and just to head on, we have about 700 employees, 700 employees here in the U.S. and principally in the Alaska and the Puget Sound area. We have offices in Tacoma and Fairbanks and Prudhoe Bay and about 350 or so here in Alaska. The other 350 or so in the Lower 48, and so we have been very fortunate.

We're part of the -- recently, in the last year-and-a-

half, we've become part of the Saltchuk family of companies, otherwise known as -- a subsidiary of that is TOTE, Inc., and we have been very fortunate in our findings and our healthcare that the costs of healthcare have not impacted our employees or ourselves as much as what I've seen elsewhere.

I've been with some other Native corporations, as well as I mentioned earlier, Wells Fargo, and we find those cost increases and the healthcare claims costs going up significantly. I haven't -- this is the first year I've seen it at Carlile and we've been very pleased at what we have seen so far, but as a whole, nothing that jumped out at me that was a surprise or caught me off guard.

CHAIR HURLBURT: Do you buy insurance or do you take risk, or do you have an ERISA plan for your.....

MR. ALLEN: We have an ERISA plan. We're self-insured and have been that way -- I don't have the history, but we've been that way for a couple of years, I'm sure. I don't -- I don't have all the legacy with Carlile that some other employers -- individuals might, but we've been self-insured and we're looking at consolidating from the Saltchuk perspective, we're looking at -- and the TOTE, is how do we put all of our companies -- we also, here in Alaska, we have Northern Air Cargo, Foss Marine, Inlet Petroleum, Delta Western, all of those companies are part of the Saltchuk family and so we're looking at how we purchase in a greater

group of power, so -- but from Carlile's perspective, we've been very fortunate this year, so far.

CHAIR HURLBURT: Okay, thank you.

MR. HARWELL: Yeah (affirmative), I think from Doyon Universal's perspective, we -- there were no surprises in there. We -- I think the notion that I'd like to point out is the competitive edge that insurance drives and through our company, we're in a very competitive market. We're an oil field services support company. So we do catering, hospitality, janitorial services, and security services, and high profit, low margin.

So any increase in our cost of insurance drives our ability to win or to lose contracts. So I think it's very critical that our healthcare costs continue to maintain those. We are self-insured and unfortunately, we've had some very significant losses over the last couple of years, as our workforce is aging, like many workforces and cancers and whatnot, it's quite expensive, so -- but no, I didn't see any surprises.

I mean, a little, I guess -- a bit of surprise at how many companies don't insure their people or people have insurance and they offer it to them and they don't accept it and that's actually depressing, I guess, but we have raised our insurance rates over the last year. It's the first time we did in about four years and we're probably going have to

raise our employee share again this year. We're not sure yet.

MR. BOROWSKI: I think you're going to get a common theme of no surprises. CH2M Hill is a self-insured company, 27,000 worldwide, 14,000 here in the U.S. As a self-insured company, we look at the whole U.S. together. So it's interesting when you can compare and contrast the premium rates that the survey showed, Alaska versus Lower 48, we don't differentiate based upon the premiums for Lower 48 versus Alaska. So your data might not actually tell you the total picture.

What's interesting is when we start to talk to our insurance provider, our administrator, Cigna, they would actually say to us, and actually, they booked a meeting with me about six, eight, nine months ago, and said, "Florian, why is your costs so significant, greater than every place else? What do we need to do to help you build awareness and wellness programs, et cetera, to help you reduce your rates," and I had to only snicker because I'm going, "Okay, well, that's only one of the parts of the picture," because they were looking at, you know, why is Alaska more expensive, even though you have only 10% of the workforce and you're covering significantly more of the cost for the firm.

So I think one of the challenges is, as a firm that has a significant number of employees, Alaska is pulling on my firm negatively and it's very conscious to the people who are managing the millions and millions of dollars being spent.

They're going, "Hey, you're getting more than your fair share."

So I'm worried about it from a cost competitiveness standpoint and a sustainability standpoint when CH2M Hill has the options to be able to employ people elsewhere, they have the ability to say, "Well, maybe we need to employ them else -- you know, some place else, not just Alaska."

So it's clearly an issue, but I think that part of your data might have missed part of the picture because some of the larger employers, as a self-insured, try to have the same premiums throughout, not just in one state, so I guess -- and then another thing that did surprise me is my career's been primarily in large and companies -- larger companies, and so I was surprised by how many smaller firms don't provide coverage and how many people we have in this great state of Alaska without coverage. So I was a little bit surprised, just because I'm a little bit naive.

CHAIR HURLBURT: So you said you have 2,200 employees here, just 10% of the CH2M Hill's employees.

MR. BOROWSKI: Yeah (affirmative), they're about.....

CHAIR HURLBURT: But you manage them as one risk pool with the same premium.

MR. BOROWSKI: That's correct. That's correct.

CHAIR HURLBURT: That's fascinating. Are you aware of others that do that?

MR. BOROWSKI: I.....

CHAIR HURLBURT: Is that common in -- I don't know.

MR. BOROWSKI: You know, I think if you were to talk to a lot of larger employers, especially the self-insured, I think you would find that to be the same. I couldn't speak to specifically some of the other majors in the state, but I think a little bit of inquiry, you probably would confirm that.

CHAIR HURLBURT: Is your bid/loss ratio something you can talk about or that you know what it is based on those 2,200 employees and the premium that's being allocated?

MR. BOROWSKI: I'm a generalist, so you have to -- bid/loss (indiscernible - speaking simultaneously).....

CHAIR HURLBURT: Well, okay, bid/loss actually means how much of your premium dollar goes to pay for medical care costs, and you know, with the Affordable Care Act, there was a requirement in group plans that it has to be at least 85% on plans under the ACA or 80% in individual plans, but any insurance company, one of the things they report is what their med loss ratio is in their publically traded plans and Wall Street follows that and the lower it is, the better it is for the stockholders, kind of thing, but it's something that you look at because you're, obviously, going to have some administrative costs above that. If you're a publically traded insurer, you're going to have some profit margin of a

few percent.

So it's what, of your premium that's being paid in this total group of 27,000 employees nationally for your 2,200, are you informed, and if you are, is it something you can share of 100 and how much percent of that premium is being paid for medical care costs here?

MR. BOROWSKI: So respectively, I -- I would have to get my corporate benefits person to be sitting here, instead of me. He knows all these details. So perhaps at our next meeting, if you're interested, there's someone better prepared for that detail, you know.

MR. FOSTER: No particular surprise, I think, but a few observations I'd like to share, one with respect to the seasonality of our workforce. Keep in mind that summer seasonality also has a winter seasonality component that is frequently absorbed by school districts across the state.

As we gear up for that winter employment, we frequently take on those folks who are working in summer employment and they come to the school districts for their health benefits, and that's a pretty frequent thing that we observe in our ability to attract and retain, is we really are getting a number of folks as a result of the benefits that we offer and we can frequently offer a relatively low wage, because they're making more money in these summer jobs.

So one of the reasons that some firms might report that

they're not offering insurance is because they don't have to. So that's another complication, as you think about the Alaska marketplace and that relationship. We see it especially in places that you might imagine, Dutch Harbor and out in Kodiak, and when we have conversations with other school districts around the state, and we see some of it here in Anchorage, as well. So it's just an interesting complication.

The other thing I would observe, we have approximately 6,000 full-time equivalent employees and when we look at our teacher pool, which we contract with and they have a trust plan, we really just pay them an amount of money in the negotiation and then they manage.

The other employees, we are self-insured for, and that's about 2,000 lives there or 2,000 employees, excuse me. So we really do sort of have both of those management challenges and we find that, as you might imagine, you can see differences in those pools based on the composition, the number of pregnancies that you have relative to the pools and those kinds of factors, and they become very much different pools and different management is required and different sort of claims characteristics as you work your way through, and I think that's one of the other things that will tend to skew data when you're doing comparisons.

It's really not just a risk adjustment for age, it really is sort of the density of the pool, in terms of that pregnancy

amount, because you'll find, at least when we do some comparisons with other districts around the country, we're paying a premium for claims, basically, and you really do see it in that particular area, even among younger demographics, I've got to skew upward, in terms of the price comparisons. So those are some of the interesting things that we see.

We continue to see, when we drill down into our data, that this is primarily a claims-driven cost growth in high cost specialties, including cancers, heart, and diabetes type care, and that family takes up a bunch, and coming in right behind now are, what I'll call back problems, and we're seeing that jump into that pool. So those wind up being the areas where I spend a lot of my time going, "All right, how are we going to negotiate and get good value in those specialties," and I think that's one of our common challenges, both public and private sector, as those prices per procedure continue to escalate and so we continue to have a lot of frustration with that payment model and I think it's reflected in the high prices and the lack of sort of economic incentive for people to be on that, because they prefer to have wages when they're younger. So I think those dynamics are very much reflected here. Thank you.

CHAIR HURLBURT: Okay, Lincoln.

MR. BEAN: I've heard of the first three that you mentioned -- I'm sorry, my voice doesn't carry. I heard your

first three on that needs, but it's surprising, the first time I've ever heard of the back problems. What -- how are they related? What's going on there?

MR. FOSTER: Mostly what we're seeing are folks who are -- and these are medical claims, not Worker's Comp claims, so that's the other interesting thing. As folks are aging, and it's frequently in that 50 to 65 zone, I'm seeing a higher incidence of and a high cost per claim of folks who are going in and going, "There's something wrong with my back," and then they start looking and then you get various sorts of treatments that tend to be fairly intensive and they're showing up in my high cost pool.

Those are the, you know, those high cost claims where I'm looking at my stop-loss to carry some of that, and so it really surprised me. I didn't think we were having severe back challenges, but now, they're starting to show up in that high cost pool that I look at.

CHAIR HURLBURT: So with -- what happens with those individuals, as they retire, you have a forecast, a preview of coming attractions for Jim?

MR. FOSTER: (Shakes head in the affirmative).

CHAIR HURLBURT: Seriously, that's something to be aware of, as they come into that pool of retirees.

MR. POPP: So from my perspective, looking over the Research Summary, there's not shock and awe there. It's all

pretty much what I expected to see based on discussions that I've had with our membership and with other businesses at-large in the Anchorage community.

It is a little depressing to see the number of firms that actually provide coverage and the fact that it's become so expensive, which is clearly demonstrated by the data, that many businesses are jettisoning or not taking on healthcare over the very simple fact that they can't afford it and in a very competitive environment, where there's intense pressures, you're the 20th most expensive housing market in the United States in Anchorage.

You're the 26th most expensive city in the United States in Anchorage, based on the Cost of Living Index 2013 year-end results. So that's a very uncompetitive environment to be doing business in, and that's only amplified, would be my assumption, in many other cities and communities across the state. Alaska, as a whole, is just a very expensive place to do business.

When we look at the Cost of Living Index, healthcare is only 5% of the weight in the index. Housing, as an example, is 26% of the weight, but it doesn't mean that it's inconsequential when Anchorage, when we look at those numbers, is the fourth most expensive city in the United States in the Cost of Living Index for healthcare.

I'll absolutely bet that you can't guess which the top

three are, Fairbanks, Juneau, and Kodiak, as the ones that participate in the survey. It is a very expensive environment in Alaska and this is a competitive pressure for us.

I want to share with you, just -- it's just -- I don't know if it's kismet or what it might be, but today, my benefit advisor came in to tell me what my healthcare premiums are going to be in the coming year. I've got my analysis right here. I was pleasantly surprised at a 7.5% increase, having heard the horror stories in the media of what we were facing, and historically, looking back, when we implemented an HRA, an FSA strategy, when we moved our employees to $100 a month copay, when before, we were paying the full nut, from 2011, our average employee cost for benefits went from $785 per employee per month to this year's quote of $786.

Now, I think we're an outlier. I don't know quite how we've managed to pull this off, other than the fact that I've got a very young staff and they don't use healthcare very often, except for the old geezer boss who runs the shop.

One of the things that was really interesting to me in what our benefit advisor brings us is an analysis of where our premiums are compared to other companies in our industry category, and they gave us a comparison of 180 businesses in the state of Alaska. The average price, and I'll let you guys do the math, is for annual cost for employees, $13,235, for the businesses all in, all shapes and sizes in our state in

our particular category.

If you get it into the size category, employee equivalent category, it's $9,540. So at $7,920, we're definitely below. By the way, the national average for our industry segment is $9,828 per year per employee and that's based on 7,473 businesses surveyed. It's some pretty good data. It's the UBA analysis and it definitely helps to inform us that we're doing the right things and that we have the advantage of a small shop.

I will tell you that I have eight employees, four of whom have insurance from other sources and have opted out to save the $1,200 a year in employee copay. So that's for four of us. I don't know what this means in the greater scheme of things. These gentlemen next to me have far more experience. I'm the guy who wears all hats and so the best that I do is I ask my advisors what's right. What are we doing right? What are we doing wrong, and what do we need to fix? Thank you very much. Let's do it. That's the sum total of my annual analysis.

These guys have to deal with far bigger, far more intransigent problems with large-scale employee basis spread out across a number of different fields that are much more challenging, in terms of the healthcare demands that they have to provide for, as well as being self-insured. I mean, I can only imagine the nightmare that is their daily job.

CHAIR HURLBURT: I have a comment and then a question. The comment is that a gratifying 7.5% increase, it probably extends out to 2050 before we're spending 100% of our gross domestic product on healthcare. So it gives us a few more years to buy food and gasoline.

MR. POPP: Last year, it was down 7.5%.

CHAIR HURLBURT: With the Cost of Living Index, 5% being made by health -- for healthcare, when as a component of our state's gross domestic product, it's about four times that, this just shows my ignorance, why is that only 5% of the.....

MR. POPP: Well, it's the national system. It is how they weight it in the overall Cost of Living Index. It's a national average. So in a normal setting, based on the number of communities participating in all shapes and sizes, it's about 5% of the total cost of living overall, according to C2ER.

Gunnar, I'm sure is very familiar with these guys, and you know, you can take it or leave it. It's about the only survey that we can find that we can lay our hands on that we feel is a quarterly survey that gives us a sense of this is not an inflation measure, this is a differential measure. If the national average is 100, we are at, you know, 126 compared to the national average in terms of overall cost.

On healthcare, we are at 139. So we're 39% above national average. Some stats, it's -- and this is not a

perfect tool, okay, this is just taking some basic pedestrian costs and using those as a measure. So as an example, a full vision eye exam in Anchorage is 71.6% higher than the national average, according to the sampling that we -- we are the agent to go out and take.

A general physical is 63.4% higher in Anchorage than the national average, and a teeth cleaning is 43.2% higher than the national average, according to the Cost of Living Index. That's based on all these different participating cities going out and getting the same number of samples, varying them from quarter to quarter from different providers, so that you get a good cross, you know, average, and these measures, along with a couple of other, you know, like an over-the-counter cost of a 100-count acetaminophen and some other things that kind of contribute as kind of -- it's, again, not a perfect vehicle, but it's a finger in the water to get a sense of temperature, in terms of how we're doing compared to the rest of the country.

CHAIR HURLBURT: Thank you. Can we go on to the second question, Deb?

MS. ERICKSON: (Indiscernible - too far from microphone).

CHAIR HURLBURT: I think it's probably in my mess here somewhere. Okay, the next question, and we'll just go in the same order again, and maybe you could go ahead and address the three components of it, have you in recent years or are you

considering potential future changes, and this is what I was asking you about, initially, Todd.

MR. ALLEN: Okay.

CHAIR HURLBURT: And we'll be interested to hear what you've done, and are you moving away from more traditional comprehensive plans to high deductible or consumer-oriented plans,.....

MR. ALLEN: Okay.

CHAIR HURLBURT: .....other alternative ways and including a comment on the medical tourism, sending folks outside Alaska, are you currently exploring and contracting with Centers of Excellence?

MR. ALLEN: Okay, so here, at Carlile, we are moving away from more traditional comprehensive plans to high deductible. The high deductible healthcare plan was introduced to Carlile last year. I am enhancing that this year for the programs. In fact, I have a meeting at 2:00 with all of our leadership team to explain to them what we're going to do for 2015.

I do take, not exception, if you will, but I've been working with high deductible healthcare plans, HSAs, and HRAs, since 2005, and I usually use the term consumer-driven health plans, instead of the high deductible healthcare plan. It's a matter of perception to the employees.

As soon as they see a high deductible, they're thinking, "I'm going to get whacked." That's what they think. They

think, "Man, you know, you just went from $500 deductible or a 25 or 700 up to, the minimum deductible under a high deductible healthcare plan is 1,250," and so they see this high deductible, you know, I'm going to get whacked on this.

So I use the term consumer-driven healthcare plan so it's a perception of it that's actually driving the behavior that you want to change in the employees to actually how they consume their healthcare expenses for them and their family members.

So I'm not necessarily changing it for the Cadillac tax reason. I hate to say it this way, I'm really not too concerned about that Cadillac tax for a couple of reasons. Number one, the Affordable Care Act has changed over the last couple of years, as it is. I believe it's going to stay where it is. I don't -- I believe there will be more tweaks to it, and the other thing, there is the potential for Alaska and Hawaii for that Cadillac tax to change. It will be indexed to inflation, as well. So I'm not so much concerned about the Cadillac tax on it right now.

From the perspective of Carlile, our premiums are well under the Cadillac tax. The threshold, as it stands right now, and I don't see that we're going to even come close to that. To Bill's point here, a few minutes ago, I got our renewal back a week ago, Friday. For our healthcare costs, our renewal was only up 3.6%, and it's just like, I did a jig.

That was great.

We have one of our other companies who hit a 27% increase and of course, the smaller the population, and a couple of claims are going to throw your -- skew it all out of data, and so when I saw 3.6% and my dental went down by 4% and my vision went down by three or 4%, I'm sitting there, I've got good news for employees this year. It's a really good thing.

So kind of long there, sorry about that, but I am moving to a more -- a consumer-driven health plan. I do not want to call it a high deductible healthcare plan. I'm enhancing that program for ourselves, for our employees.

Are there other alternative ways you're looking at providing healthcare, such as a primary care clinic? Well, we have the clinic, as you mentioned -- as you mentioned at the start, we have the H2U Clinic. It's a contract with H2U out of -- they're actually out of Nashville. We have it for our clinic here in Anchorage and I have not been able to completely analyze all the data that we have with regard to is it a significant cost savings? What is -- you know, I know what the costs are on a per head cost. It's much cheaper than walking into the local, I call them doc in a box, it's much cheaper than walking in there.

We get pass-through on our prescription drugs and things of that nature. So there's no markup to that. So we have a very good program. Empirically, I believe that the H2U Clinic

has been very effective in helping keep the Alaska, and Anchorage in particular, healthcare claim costs down. It's available to all of our employees who are enrolled in healthcare and to their family members. So it's a very good deal.

It was not something that I was familiar with. I mean, I'm familiar with medical care clinics and what they have, but when I came to Carlile, one of the first questions that my leadership asked me was, is this a good thing, and I said, "This is a fantastic thing." What you want to do, and of course some of the data, excuse me, some of the data that I'm sure we pointed out, is going to a healthcare clinic, such as an H2U or there's another company called Vera Whole Health out there, if you go to those, as compared to going to the emergency room and having to pay the charges for the emergency room versus paying the charges for a doc in a box, is much less going to the facility like H2U. So we are looking at alternative ways in that way.

The problem I have at Carlile is that we don't have that type of clinic set up in Fairbanks, Prudhoe Bay, Kodiak, Seward, Juneau, well, we don't have it in Juneau, in Kenai, and I don't have that clinic set up in Tacoma where I have essentially -- Tacoma and Federal Way, which essentially is where I have half of my other employees. So I'm looking at ways of what I can do with some other contractual arrangements

down there.

CHAIR HURLBURT: So you mentioned you had -- so I think it is your assumption, but do you feel that the use of this clinic, with lower cost providers with maybe more of a medical home concept, has -- was a significant factor in the 3.6% increase?

MR. ALLEN: I think so, but I can't -- I can't -- I can't be -- I can't sit here and say, "I've got the stats to support that," but I can say I believe that. I'd like to believe that. After I've been here a little bit longer and I get some more stats and I get some information, more about H2U and so forth, and what they're doing for us, I think I will be able to support that.

CHAIR HURLBURT: So in Fairbanks, for example, do you know -- have you all approached Banner Health, which are -- which is doing some innovative things in the Southwest.....

MR. ALLEN: No. Yeah (affirmative), no, we haven't.

CHAIR HURLBURT: .....(indiscernible - speaking simultaneously) to see if they would be interested?

MR. ALLEN: No. I'd like to do that. I mean, I've been approached by a couple of other vendors to work in that area, but I haven't done it yet. The last one is, do you currently -- are you exploring contracting with medical centers of excellence outside of Alaska? That's medical tourism. Yes, we are. We have to.

You know, I'm actually putting in that program, the medical tourism program in our program this year. It will start on January 1st, 2015. I am familiar with it, both from -- Florian and I've talked about this before in different organizations and different programs that we work, different companies I've had, and there are some healthcare services that are not provided here in Alaska that can only be done in the Lower 48, typically Seattle.

I mean, we've had -- actually, when I was with another company, we had folks who we were bringing in from Kodiak and we had to ship them down to Houston, but we have to do those types of things. The -- but that is being -- I am introducing it for the 2015 year.

There are some services that are not provided here. There are other times that it's an alternative service that's, obviously, a lower cost impact to our employees in the Lower 48. So it is something we're considering and putting in place.

DR. GUETTABI: Do you predetermine what types of procedures are eligible or is it a case-by-case basis?

MR. ALLEN: No, case -- very good question. Yes, case-by-case basis, it's -- and we're going to look to the attending physician. We're going to look to -- for an example here, and obviously, I'm not going to use names to protect HIPAA and so forth, but we had a case out of Kodiak a couple

of years ago.

The patient came to Anchorage and the doctor who was the attending physician here said, "I cannot perform this surgery here with the staff, nor the equipment that I have at here at Prov." He recommended that we send that person down to Seattle. There's the recommendation. So that's what we did in that case.

DR. GUETTABI: Excellent.

CHAIR HURLBURT: Thank you.

MR. HARWELL: So on the first part of the question, I mean, we're considering all options to lower cost, but right now, we're not considering any high deductible health plans. We're probably more of a traditional healthcare plan.

Alternative ways of looking at care for employees, not necessarily through medical or dental insurance, but our Worker's Comp claim carrier, we do have an arrangement with one of the hospitals here in town. We get a considerable break there, but we have not considered that for healthcare, and like he was saying, Todd was saying, we are considering sending people out.

Doyon Limited, one of our owners, has -- they're in a separate insurance plan than we're in. They do send people regularly, or I don't know how regularly, but down to Seattle or other places for care. We have not yet in our company, but certainly would consider it because of the cost and also

because of the unavailability of care or for that particular procedure in town.

MR. BOROWSKI: So at CH2M Hill, we introduced high deductibles, I can't remember if it was two years ago or three. We've actually seen an incredible uptick, in terms of people taking that as a plan. We've also introduced the same language that we described, in terms of it's a consumer type style or approach and so we use that exact same approach in terms of language, and actually, there's a desire or move towards only providing high deductible plans, in terms of where we're going as an organization.

In terms of the alternative ways, CH, as a company, we're, obviously you've heard, one of the larger locations, in general. CH is across the country and so we've really never had any type of provider or direct care options.

On your last question, we actually introduced medical tourism midyear, probably one of those things you don't often see, in terms of mid-plan. Basically, what we saw was the employees were so frustrated about their ability to obtain reasonable care at reasonable prices from the specialty area networks or the lack of networks that I went to our plan administrators and said, "What do we do? How do we fix this," and they said basically, "We're going to pick out 20 items, 20 types of care activities, and we're going to authorize people to have a choice," and so it's all employee-choice driven and

where do they want to go?

Our plan administrator basically picked -- figures out where they can best obtain that care, whether it's Phoenix or whether it's Minneapolis or it's Seattle, and then that's where we're sending them, and we're saving a lot of money, and obviously, we make it employee-driven because, obviously, there's choices in that. There's a level of discomfort that our employees have leaving the state of Alaska. You know, it's the follow-up care and the like.

So I guess I would, you know, you can hear me kind of petition, we need to fix this problem, because it's not good for Alaskans. It's not always good for the stress level and the like. It's not good for our providers either, but for whatever reason, they are creating a noncompetitive environment and whereby the competitive nature of the American spirit says, "I'm going elsewhere. I'm going to choose." So that's what we've done. We've given them choices and people like choices, and then -- so I guess that the answer is, you know, we are figuring out ways to help empower our people to manage their own costs, because ultimately, our plans, they do incur part of those costs, they, themselves out-of-pocket.

CHAIR HURLBURT: Two quick -- go ahead, Representative Higgins.

REPRESENTATIVE HIGGINS: Just a quick question on that tourism package. Did you find when you did the research, did

you find that it was the physicians' fees or the hospital fees that were out of alignment or both?

MR. BOROWSKI: Well, it's -- it's a bit of both, but it's those specialty providers and whether they're working inside a hospital -- so I'll tell you one of the other frustrating items, our plan administrator really struggles to -- whether it's the codes they use -- so you might have a specialty provider that's in a network hospital, but then they think they're in a covered hospital, but that provider comes in and now they're not covered.

So it -- the lack of networks and the lack of the ability to have that transparency of who's in, who's out, whether they're in a hospital or they're not in a hospital, it becomes a real challenge for our employees. I apologize, but it's a complicated answer for a complicated issue.

CHAIR HURLBURT: And two questions, 1) other than reduce coinsurance responsibilities for a lower total overall bill, do you have financial drivers, do you totally cover the cost of their travel, hotel lodging, meals for somebody that accompanies them or make their coinsurance or copay provisions lower or something, and the second question is, are you using any quality kinds of data or seeing to obtain that to drive an employee decision to a center of excellence?

MR. BOROWSKI: So the -- let's start with the quality question. The quality question is absolutely a decision to

decide whether or not our administrator will authorize a person to go to a certain provider, so absolutely, in terms of where they may go.

In terms of the actual cost relative to that tourism, it's built into the whole rate. So that the flight down, the care, hotels, are built into the whole rate.

MR. FOSTER: Is the District moving away from traditional comprehensive plans to consumer driven plans, and I enjoy them because of the impending high cost tax, the excise tax on high cost plans? I think the short answer is that was more of a factor over the last 24 months than it is right now.

When we were negotiating one of the contracts and we extended out on the existing, at the time, compounded annual growth rate, that tax will begin to hit by 2020. That became an item in the negotiation and one of the items that enabled us to reduce, basically, the spend we had for healthcare and shift more cost to other places besides healthcare and sort of rejuggle it. So it has made an impact.

I think now, as sort of more water has gone by under the bridge, there's less fear of that in the conversations we have. So it's not as much a factor as it was earlier in the cycle.

The other thing that we're seeing is people are continuing to see now, more as they're getting closer to it, that those medical benefits are part of that employment

package and it's taking away from and crowding out direct compensation that they could get, and so we're seeing more interest in how do we rebalance that. So I think that's becoming more of a factor in driving, I think, some of the leadership in the bargaining units toward making some movement toward taking on more costs on the employee side.

I think you'll find the teachers, in particular, are paying a significant amount in their deductible, relative to many other government employees around the state. I think it would surprise you. They are in high deductible plan status, for the most part, today. So I think that's an interesting piece.

Are we looking at providing medical care for employees? Yes, primarily on the basis of pitches that we've received from people who are bundling up, basically, clinics, and based on the stuff that I have seen from them when I probe, I believe the marketing, relative to the value proposition, remains modest, and so we haven't closed a deal on any of those opportunities at this point.

Are we looking at exploring contracting with medical centers of excellence outside of Alaska for certain procedures? That is an item about which we are having conversations, but in our particular environment, we have bargaining units to work through and I think we still have a lot of anxiety about people going, you know, "Would I have to

leave my doctor, or how does that work," and so we're really -- I think it's taking more time than I would have imagined, just to work through those issues. So it's on the list, but it does take time.

CHAIR HURLBURT: Thank you. Bill.

MR. POPP: From a large employer perspective, what they said. I can't really add much more to that in terms of what I'm hearing from my membership. From a small employer perspective, I'll give you my current situation.

On your first point on moving away to some type of high deductible plan, not until I absolutely have to. It is a competitive advantage for me to offer the high quality plan that offer to my employees. I have a hard enough time hanging onto them, because they're constantly being poached by my members and my partners, and so yeah (affirmative), it's important for me to stick with our quality -- our high quality plan as long as we can from a competitive point of view. We're an outlier.

Are we looking at alternative ways to provide medical care for employees? No, not at this particular point in time, unless I get advice -- piece of advice from my provider of insurance that this is an alternative that I should consider and then I'll look at it in the greater context of what I'm trying to do to maintain the quality of my organization.

Are we contracting with medical centers or shipping

people out of state? Our plan does allow for that. It -- it's not anything that we've had to take advantage of yet. However, I'm hearing a number of our member employers and non-members who are taking advantage of this, because it just makes sense. It's dollars and cents. You know, why would you spend $20,000 more on a procedure here, when for $5,000 worth of travel costs, you can ship somebody out of state and save $15,000? A plus B equals C. I mean, it's just -- you'd be stupid to do anything else, as a business leader, and somewhat negligent.

What we're trying to do is we're trying to prevent use of care. We're trying to reduce consumption and we're trying to improve the health and mental well-being of our employees. We're doing things like medical screenings and incenting those with the help of our insurer, so that they go in and get a sense of, you know, even for the non-participating members, I want them to know what their cholesterol count is, and I want them to know what their blood pressure is like. I want them to know if they're prediabetic. I want to know if I am.

We are also working on a strategy, as an organization, through our Live.Work.Play effort, through our workplace well-being area of focus that is a combination of providers and insurers and business people, who are working on strategies to launch workplace well-being strategies in the broader business community, things that are relatively inexpensive to implement

that can elevate the overall health of the workforce and try to reduce the consumption of this very high cost product. So that's our direction, at least, both as an organization and through our membership.

CHAIR HURLBURT: Thank you, Bill. The final question is; how are healthcare costs in Alaska impacting your non-healthcare business decisions? Florian alluded to that earlier. In a meeting with my counterparts from other states last year, we heard that among the finalists for a major manufacturing plant that IBM was building, the deciding factor for them to go into Iowa was because healthcare costs in Iowa were cheaper for IBM than they were in the other competing finalists for that.

So are there factors in other things, like I've heard Mark say before, and the Legislature, that the ability to raise teachers' salaries is impacted on by the dramatic increase in healthcare costs. So in your individual businesses, what offsets have you seen that have made you -- made it difficult for you to do other things, expand business, raise salaries, or whatever, because of high and increasing healthcare costs? We'll start with you, Todd, again.

MR. ALLEN: Well, I haven't seen anything directly within the Carlile family of companies that has -- that we have had to look at the high healthcare costs and how it affects business. I can say, though, from prior experience, high

healthcare cost has a huge impact on margins.

We all work on margins. It's as simple as that. It can be 5%. It can be 10% or whatever your margins are, and when you've got healthcare costs cutting into those margins, that's profitability for the company, and when you lose the profitability of the company, you're talking about the livelihood of that company, its employees, its family members, its wages and everything else.

So I take that as the holistic approach on it, is what I've seen in the last, especially in the last 10 to 12 years, within the -- specifically to Carlile, I haven't seen that yet, but I have been very fortunate, as I mentioned earlier, that right now, I'm only dealing with a 3.6% increase and actually, the way I would structure it for our employees for 2014, excuse me, for 2015, I've actually structured it such that the actual net impact to the employees is a minus 4% decrease in premium structure of this year. So I'm looking real good this year. Next year, I'm not so sure about, but I'm also near retirement, too.

MR. HARWELL: I think for us, the health -- the whole benefit package is a consideration. You know, do we reduce our 401(k) contribution to our employees because our healthcare is going up? Do we do away with our 401(k) contribution because our healthcare costs are going up? So we're struggling with that currently.

Again, as Todd said, it's all margins, and ours are very small margins, I might add. So you know, every dollar matters. So that total benefit package -- and we don't want to reduce the benefit package for our employees, because we value them. We spend a lot of money hiring them. They're few and far between, as Bill mentioned.

A lot of our clients, like my good friend from CH2M Hill, poaches our employees quite often, as does our other clients, like ConocoPhillips and others, which is good for our employees, but -- and we have a small labor pool. So we've got to be able to keep and attract those great people in this state and we, obviously, are very adamant about hiring Alaskans to work in Alaska. We're very proud of our Alaska hire rate and we want to continue that, but this whole package, it comes together as being able to find these folks, so yeah (affirmative), the answer is yes, in the total benefit package scheme.

MR. BOROWSKI: So I think I'm going to echo two words. One was not directly, and then a total benefit package is definitely the theme for us, as well. What we see is, as a company, we're being expected to manage the total. So for instance, we've had to discontinue things like our frozen sick time that we used to have. We've had to change some of the 401(k) matching components.

So when you look at the total costs of employment,

sometimes you might not say, "Okay, I'm going to have less employees in Alaska and more in Seattle or more in Denver or more in Atlanta," but it's about what am I going to do in terms of pulling the levers I have available to us. So that's what CH2M Hill is doing, is pulling these levers about reducing other components to try to minimize the total cost of employment.

One of the things that is interesting is several of our contracts -- we're a provider of services to a lot of the major producers here and I've actually found myself sitting in a similar type of forum where we're actually having to justify our throughput cost charges to our clients.

When we say we need a certain type of multiplier to be able to just breakeven, you know, some of their procurement folks would say, "I don't believe you," and it takes data and information to be able to say, "No, believe me. This is the breakeven. This is what is costs to do business in Alaska."

So what we find is a need to be able to have data and information, because sometimes companies are going to say, "We think you're just going -- you're taking that as margin," and the answer is, no. We have to educate non-Alaskan procurement organizations about the cost of doing business in Alaska. So there's a lot of education that occurs just to do what we need to do.

MR. FOSTER: As I think I've alluded to before, the total

compensation package, the medical costs are crowding out the salaries that we can offer. That becomes a particular challenge for Anchorage, because this is a pool where we hire 60% of our new teachers from out of state, because there's not an adequate supply in state to meet our needs.

Our -- we've got 3,400 teachers and that annual churn, even without budgets going up and down, if you're just looking at the annual turnover in that pool, I've got to easily hire 200 to 300 new ones every year, and there's not an adequate local supply.

In order to be competitive, I have to offer salaries that are competitive, and when I cost adjust, I -- for basic cost of living in Anchorage versus other districts, I am not below the 50% percentile, and it is hard to attract and retain people who are in the mobile portion of their life and they're able to move, it's hard for me to grab them and hold them.

It's a beautiful place to live, but if I'm pulling them out of Colorado, where they get a little more sunshine and they like the outdoors, it's tough, and we really are getting the squeeze on the margin and we're finding our vacancy rates are rising in positions, because I can't offer a competitive package.

CHAIR HURLBURT: Your benefits cost about 45%, is that correct?

MR. FOSTER: Not including the pension, yes.

CHAIR HURLBURT: Okay, do you have a sense of say, somewhat comparable size, competitive cities like a Spokane or Albuquerque, what would that comparable percentage be for comparable benefits?

MR. FOSTER: If I look at my all-in benefits that I pay and not the portion of the pension that's covered by the state, so let's be clear about what I'm looking at, even though it's not an all-in cost, if I just look at that, I frequently find, I am twice as high as a Spokane or even a Seattle or a Portland.

MR. POPP: Florian and I were sharing a smile because we were both in a workforce, Alaska Workforce Investment Board meeting yesterday, in which there was a growing recognition that with the incredibly tight labor market that we have in Anchorage and the generally tight labor market that we have across the state, this idea that we can grow our own, in terms of workforce, is becoming more and more debunked with each passing month.

We have to be competitive on a national level, and so there are any number of components that go into that competitive proposition that you're trying to put out there for key skill sets, like the medical field, like engineering, like skilled technicians, like you know, oilfield workers, where you're trying to offer them an opportunity to come up here because it's an overall good idea for them to do so, and

that's getting harder and harder and harder to make that case in any number of career fields, because of the competitive opportunities that they have elsewhere in the country, where they may make less money, in terms of an annual salary, but when they hit the end of the year and they look at their bank account, they've got more money in that bank account, because the cost of living is substantially less.

You know, some -- I go back to the Cost of Living Index because it's a good metric. When you look at Laramie, Wyoming, it's 98% of the national average. When you look at their healthcare, it's 29% less than our healthcare in Laramie. You drag in, this is a favorite one, Fargo, North Dakota, because North Dakota, of course, is the boogie man in the oil patch right now, our big competitor with shale oil, Fargo, North Dakota right now is 93% of the national average of cost of living, and their healthcare, when you look at the healthcare number, let me get across here, is 27% less, in terms of a comparative, compared to the national average, and then even Seattle, our friends to the south, when you look at their data, they're at 20% less on healthcare and their overall cost of living is 20% less, so in terms of the cost differential.

You know, it's a real challenge for us to compete for this diminishing labor pool with the big retiring out that's going on nationally with the baby boom moving onto their great

reward, with the gap that we have in the millennial generation, in terms of the smaller population cohort that's coming through. It's creating kind of a double whammy. So either we've got to get people to wait longer to retire, which is becoming more and more difficult, as this population ages, and they're pretty much done with that, and then trying to find that bridge to get us to this next generation after the millennials that, excuse me, it's GenX that's the smaller cohort and then the millennials that are the bigger cohort. We're trying to get to them and get them trained up and hopefully, ready to fill the jobs.

So it's going to be a gap that's measured in many, many years, and we keep, you know, looking at this from a very myopic perspective, in terms of policy focus, et cetera, and healthcare is an issue that we really do need to focus on, in terms of trying to drive down the cost to make us more competitive, because you're at -- these gentlemen all expressed it, it's all part of the bottom line, and you know, you are able to only offer so much before it becomes foolish to do so, because you're putting the business at risk and its competitiveness at risk.

CHAIR HURLBURT: Thank you. We'll take one question. David, you had one earlier.

COMMISSIONER MORGAN: Yeah (affirmative), this is for my friend, Mr. Foster. I have a study in my hand, which I also

used -- I have a study in my hand, that was actually prepared by the Legislature, called the "Hays Group Report." You've seen it. I just wanted to make sure I've got this right.

I'm looking at 53 of the 54 school districts, which are broken out by size, and it's showing that the state and local federal funding was 1.7 billion, number, that total employer healthcare costs were running 15.6% of the entire funding stream going in. It says project FY14 base needs with their ADM adjustments, basic school allocations, one district's not included, Mt. Edgecomb, and I'm assuming you're in the -- one of the four school districts between 1,000 and 6,000 employees, which it's running around 14.2% of those top four. Is this -- I'm assuming you've seen this or probably contributed, is that -- and it's crowding you, by this report.

MR. FOSTER: They used our data, that's correct. I believe they underreport the magnitude of the challenge based on how they sampled.

COMMISSIONER MORGAN: And I guess, a Part B, and it's for my friend from Economic Development, it's anecdotal, I swear, three, two years ago, I was sitting in one meeting, the same day, and your organization, it might have been your -- I think it was your predecessor was giving the annual economic report and said, "This is great. Anchorage has this booming industry. The UMED District has $60 million of medical construction. We've just -- it's our top performer as an

industry," and then later that day at Commonwealth North, I hear our biggest healthcare -- our biggest problem is healthcare costs. It's eating us up alive and hitting our margin. It's almost, from a micro sense, Anchorage, and as a person that lives in Anchorage at the UMED District and has watched this grow, it's a positively boom economically, the health industry, but from a macro sense for industry, the costs are being transferred in.

At the Primary Care meeting the next day, and 2/3 of the same people are in the same room. It's always the same people, no matter which place you go, at least 2/3 of them are the same, and I asked Commissioner Streur at the Primary Care -- and they group meetings in groups, too, and he said, "Well, sooner or later, we're going to have to balance the books."

The issue I'm bringing rhetorically is, on one hand, Anchorage is the medical center. UMED is the center of that. Hundreds of millions of dollars of healthcare stuff, salaries, building, all that stuff's going through there. On the other hand, these costs are killing us, is what I'm getting, and crowding us out in the public sector, and Commissioner Streur said, "Well," looked over at me and gave me that look, you know, like you're giving me and said, "Well, Dave, sooner or later, we're going to have to balance the books."

Maybe we have seen the enemy, and I won't finish the rest of this for peanuts, but how are we going to reconcile that

from a community standpoint, from an economic development position, from a -- as a guy that leads that, but at the same time, look to your left of the problems it's creating.

I don't know how you balance that without bringing down costs, which means less money comes into the economy. Hopefully, it all balances out someway sooner or later.

MR. POPP: So 45% of our job growth over the last decade has been healthcare in Anchorage, and it carried us through some fairly tough time back in the middle of the last decade. It was one of the sectors that kept growing. It probably kept growing, quite frankly, because it was the land of free, home of the brave, no price too high to charge, and so is that a policy issue?

Is that, you know, but it's been more about, you know, yeah (affirmative), it's a problem. Yeah (affirmative), it's a problem. Yeah (affirmative), it's a problem, but we haven't had significant initiatives to collaborate between the providers, the consumers, in terms of those who are basically paying the cost on the employer side, as well as the consumers -- remember, there's 65% or so who are not covering it. So there's government agencies that are involved in this and then there are the uninsured.

It, you know, it's a giant fur ball. I don't disagree with you. It's a giant fur ball. Yes, we've benefitted greatly from incredible capex and we've benefitted greatly by

now being able to offer services in the state that we previously had to ship people out. I remember those days, you know, so it's -- it is a two-sided coin and we've got to start, you know, figuring out how to get to those solutions.

Our organization is doing what we can, in terms of on the consumption side. The bigger issues are, you know, just in the vernacular in this room that's being used in the discussion, I mean, you know, honestly, you get the average employer in here and they wouldn't understand half of what is being talked about, because it has become so complex and so arcane in the language that there's a disconnect, and so the public is just going, "Well, you know, I have no dog in the fight. I don't, you know, I don't care. The insurance is going to pay for it," and the insurers are going, "Well, hey, you know," so then they get upset when their insurance premiums go up, and you know, there needs to be a much bigger discussion beyond a room in the Dena'ina Center in the broader community that's going to have to start involving employees, employers, providers, policy-makers, that are going to have to start to wrestle with these issues, because you're right, it's coming to a balancing point, and there are many players in that equation that I just described that aren't going to like outcomes and that people are going to lose jobs over.

COMMISSIONER MORGAN: Thank you.

CHAIR HURLBURT: We probably better move onto our next

session, and we appreciate all you folks coming for this one. We appreciate, Mouhcine and Gunnar, the analysis that you did. It will be an important document that we have going forward.

If we could just go ahead, and we've got three questions, again, for the -- for the next panel that we have. The first is, what's HR, Alaska HR Leadership Network, what business do you represent, what are your purposes, then any further thoughts on the panel we just had and finally, what is the Network's and your individual perspectives on how we could and should all go forward.

So I would like to maybe ask if we -- since our -- we've already eaten into our time, maybe try to give the biggest chunk of time to the third question of where are you and where are we going to go forward. Florian, do you want to maybe start and just talk a little bit about the HR Network and a little bit of history, how it came together, who you represent and.....

MR. BOROWSKI: Well, thank you, Chairman. The -- Todd Allen, who just walked out and was part of our earlier session, actually helped convene a group of senior HR leaders from across the state, probably in the neighborhood of a year-and-a-half ago or two years ago, and this is one of the times where we said to ourselves, "Well, what is the common issue? What is the common concern that we have as the HR people leaders of our organizations," and it became quick -- quickly

obvious that the top -- one of the top issues that we saw ourselves being able to compare, contrast, and perhaps collaborate on, was the issue of healthcare costs, and so that became kind of our focus item, and so as a result of dialogue, frankly, with the Workforce Investment Board and its staff, that we became aware of your mission and your activities and therein, started a dialog with some of your senior leaders.

Debra, thank you. Ward, thank you very much, and so we created a dialog around how we could collaborate together, because clearly, we had a joint interest, and so I think we've been in a dialog for six months or thereabouts, trying to figure out how we could do something more powerfully together than we could independently and so I think that would be the background, the context that I would offer the Commission relative to how we came in front of you today, and I guess I'd ask my fellow board members or advisory group, what else you might offer.

MR. REDMOND: I'll just introduce myself, since I'm the new panel member here. My name's Tom Redmond. I'm the HR Director for a company called SostenXP, and I represent probably one of the smaller employers here today. We are -- we offer a self-funded insurance plan and we have multiple companies, a lot of LLCs, under our umbrella, but we're the parent company.

So we represent approximately 350 employees. Of those,

about -- a little bit less than 300 are on our plan. Per month, per employee, the cost is $1,400 a month. We offer a consumer-based -- I think we offer just about everything we possibly can to try to contain costs associated with our medical benefits and this -- getting involved in the HR Leadership Network and getting involved with regard to these healthcare costs was a real dilemma for me.

I grew up here in Anchorage. I've been here since '62. My dad was a dentist here in Anchorage and I saw the effects of malpractice insurance and other things, insurance companies whittle away his ability to earn a living and -- or at least, to maintain a lifestyle that he had become accustomed to, you know, and I just saw this erosion and as a matter of fact, he encouraged me not to get involved in the medical profession because of those things.

He just saw that sooner or later, we were moving toward socialized medicine, unless someone really had a passion for that, that it was probably not a very lucrative field to be going into. Now, I probably would have been okay with my generation, but going forward, I'm not so sure. You know, so I understand the business side for the medical providers.

So when we got all the information with regard to medical costs here in Alaska, there was always an assumption, I think, from all of us that we knew they were higher and we assumed that they were about 30% higher, and we just took that,

accepted it, and you know, it was just the cost of doing business here, and we, as a leadership network, had started to do this survey as to what, you know, what are we spending money on, and when we did this, we found out that the Health Care Commission was also doing a study and did the Milliman study, and when this data started coming in, it was incredibly compelling that these costs were a lot higher than 30%, especially for specialized procedures and that kind of moved me off the dime to get a little bit more involved. So that's my background, and my continuing thoughts with regard to this discussion.

So I think to address number three here, identifying the problems, looking at the issues, talking about them, creating the transparency, collectively, if we can all come together with some ideas that may help, you know, if we hide our head in the sand, we're not going to get there, but for all of the reasons that have already been spoken about today, we have an issue here that we really need to address.

I don't want to try to control the market, but there's got to be a way to get us -- get Alaska competitive in this arena.

CHAIR HURLBURT: Thank you.

MR. HARWELL: I think the network, you know, just from its makeup is quite diverse. I mean, we're, obviously -- a lot of people call us a Native corporation. We're half-owned

by a Native corporation, half by another corporation. There are banks involved. The School District's involved. There's CH2M Hill involved. There's banks involved. I don't know how many different companies. I think it was in the 25, 23 companies representing tens of thousands of employees in Alaska.

So I agree with Tom, you know, I think the notion is we need to be in this together. Deb has been able to provide a lot of information, Ward and others. I think we, as a body, the Leadership Network, we've begun work with Legislature to make change. We've supported and had our presidents and CEOs of our companies, those of us that could, sign support for resolutions and acts down in Juneau.

So I think it's, you know, we all see it's a problem. We're all willing to sit at the table. We're all in this together. We're a small state. We're got to get along and work together, and I agree with Tom, you know, I'm a former EMT. So I understand the medical profession a little bit. We don't begrudge anybody making a good living, but it needs to be fair and equitable and if it's not, as Florian said earlier, and other said, you know, our employees will start going down south and we don't want that to happen, so.....

MR. BOROWSKI: So perhaps I didn't do justice to this network that came together jointly. It really is your largest employers throughout the state and certainly is not just

Anchorage. It's well represented in all the larger communities. We've got great representation from our Native corporations, all industries, whether they be, you know, as you point out, oil and gas, mining, construction, et cetera.

So we've also talked with colleagues on the union organization side that represent and take care of the benefit cost for their members. So when this group of folks came together. We have really identified that this is an issue for public, private organizations. This is clearly an Alaska problem. It's about making Alaska competitive and we're not competitive. So that's why we created it.

We came together, said what can we do. So some of the things we have done is we've tried to say, "We need help in this space. We, as an individual employer cannot, on our own, manage this." So each, independently, you kind of hear about our plans that each of us are managing and adjusting.

You hear about the wellness activities to try to reduce the care and the needs for demand, but ultimately, people need care and what we're finding continuously is there's certain providers that -- my favorite phrase is they're getting more than their fair share of what it takes to provide medical care to our people, and so with that in mind, what we've done is we've tried to engage legislative members who are interested in helping create legislation that will create transparency and openness.

I think we've all learned a lot. We've all learned a lot that the old supply/demand doesn't kind of work in this space and we would think it would, you know. We, as Americans, who believe in capitalism, believe that it would work and in this space, my aha, is it doesn't work, and so that's why, when I said, "Okay, you need to have a different solution available to us," and that's where we started to reach out to some of our legislative members and said, "Help us."

CHAIR HURLBURT: The Health Care.....

MS. ERICKSON: Ward, come around here so folks (indiscernible - too far from microphone).

CHAIR HURLBURT: The Health Care Commission, as you know, is the creature of the Governor's Office and the Legislature and it is charged with providing recommendations each year, again, as you know, and you have been involved in supporting some of those recommendations in the past, but the -- we've identified a lot of the problems and you've alluded to some of the documentation on that and we have recommended certain solutions.

An underlying principle has been that we are recommending market-based solutions, that while some aspects of capitalism are not working, in unique aspects of the healthcare industry here, we're not recommending socialized medicine. So we are recommending market-based solutions, but what, from your standpoint, where does the state related to our position of

making recommendations to legislation to the Governor, where does the state create impediments, regulatory, legal, policy, whatever, that make it difficult for you all as employers to seek out market-based solutions, specifically related to the challenge that you face and that we heard about earlier from Mark and others, in terms of managing your workforce in a fair and enlightened way, but that enables you to stay in business and make a reasonable profit?

MR. BOROWSKI: Well, in terms of barriers, what does the state do, I guess it's what the state's not doing, might be a better description of what the state's not doing and that's enabling that transparency and enabling the providers, those specialty providers to give us information so that our hundreds of employees can truly be consumers, more educated consumers and try to be more -- that's the place we're moving toward.

We all know we're trying to give people choices. We're trying to give them options and there's not the level of transparency and information to help them be market-driven. So I wouldn't say what the state -- barriers, I would just say what it's not quite doing and that's enabling that transparency. So I think there's more that could be done in that space.

MR. HARWELL: Yeah (affirmative), I would agree with Florian. I think it's the transparency issue. You know, it's

a market-driven economy and if the costs aren't apparent, the total costs aren't apparent, then how can a consumer make an informed choice. So I think it's perhaps legislation, I'm not sure, to drive that transparency to occur throughout the state.

MR. REDMOND: And I -- the only thing I would add to that, and it's something that you are addressing, is the Worker's Compensation component. That avenue seems to be very liberal in it's delivery of money to injured workers and whatever providers are asking for with regard to compensation for the services they're delivering, and I know it's grabbed your attention. I know you're looking at it, but there does seem to be very liberal delivery of compensation.

In our company, we don't -- currently, the organization I'm with, we don't have a lot of Worker's Comp claims, so I'm not addressing this like I have in the past, but I've been involved with claims and other things over the years that I've been surprised at what's been allowed, and it hurts all of us.

MR. HARWELL: Yeah (affirmative), that piece is a huge amount of that total cost, you know, we talk about the cost of healthcare, but the Worker's Comp insurance, I mean, it's seven figures in our company, we pay for that insurance a year and it's significant, and that of course, eats again at that bottom line.

If our Worker's Comp goes down, we can provide more

401(k). We can reduce your medical care. We can give you a raise. We can hire more people. There's more profitability to our two owners, et cetera. So it's a very serious cost and we are a large employer. We, you know, are on the North Slope and other gas industries where people do get injured and we have a number of claims every month and it's very significant and it really eats away at that bottom line, and of course, we do everything we can to maintain that cost and reduce those injuries, as our clients like to see us operating a safe environment, and of course, we want to operate safe anyway, for the sake of our employees, but it's a very serious cost.

CHAIR HURLBURT: Do you -- what is your perception of why that is such a high cost to you?

MR. HARWELL: Well, in my limited experience there, it's, you know, and I only hear this from our carrier is that the Worker's Comp Board in this state is a very employee friendly board, not a very employer friendly board, and I'll just leave it at that.

CHAIR HURLBURT: Have you -- Representative Olson took -- adopted this with his committee and impressed me by getting two of his bills passed last year and got two or three more that I hope, I believe he's going to come forward with. Have you engaged in that process with his office any?

MR. HARWELL: No, I have not.

CHAIR HURLBURT: The -- yeah (affirmative), Deb.

MS. ERICKSON: I was just going to say, Allen had a question.

CHAIR HURLBURT: Okay, Allen.

COMMISSIONER HIPPLER: Thank you. Allen Hippler, the Chamber of Commerce, a lot of what you gentlemen have talked about today has been addressed here and the Chamber generally shares your opinion on these issues, especially Worker's Comp is a big one. I have a question for -- and this is probably mainly for CH2M Hill or any company that has a large number of employees actually in Anchorage, all in one location.

At what point do you feel like you're going to be forced almost into the healthcare industry where you will be -- CH2M Hill will actually be hiring a medical care provider to be in your lobby, you know, treating the spouses and children of your employees so that you can desperately try to do something?

At what point are you going to do things that really are not in the job description or business description of your company because you feel like you're being forced to do that? Thank you.

MR. HARWELL: I'll just answer before Florian answers. We have not talked about it from that perspective, but from a prehire perspective, because we have people do a prehire drug test. We have people do a prehire physical and we have people do a prehire WorkSaver functional past evaluation and we're

talking $400 to $500 per person and we hire 300-ish people a year.

Well, you do the math. Why don't we hire our own PA and take one of our offices and create our own little clinic and start doing drug test ourselves, and we've had serious conversations about that and you get into the malpractice and the insurance and the equipment and the licensure, et cetera, you know, it doesn't pencil out yet, but I'm not sure we're far from that.

MR. BOROWSKI: Yeah (affirmative), so it's a question of when do you actually start to bring the healthcare services in-house, as an employer? I think we're a long way from that. You know, we, as a company, interesting -- I mean, our largest workforce is actually on the North Slope, and so our employees, we have large volumes in the Peninsula, in the Valley, as well as in the Interior, so -- as well as here in Anchorage.

So I think we are a long, long way from that. I think there's other employers, however, that truly may have a magnitude that could justify that. I'm aware of other employers in other states that have actually gone through and brought dental clinics and actually got prepaid and managed those and you could actually, for all of us using Outlook as our calendar, actually can book a meeting, book a dental appointment, as a meeting and you can see that.

So I know that large employers are in that space, are booking and handling their healthcare costs in-house, but I think we're -- we, ourself, as an employer, are a long, long way away from that, but I think it's on the horizon, unless we can get some of these -- get some control of these costs.

MR. REDMOND: I'm aware of a couple of other organizations here in town that I think they are doing it. They are starting to provide those services in-house. I won't say who they are, but.....

SENATOR COGHILL: Thank you, guys, for coming to the Commission. A couple of things, one is a comment. From my youth, I've worked with heavy equipment, construction work and the culture of safety has been significantly different, just in my lifetime. So the -- nobody gets hurt, think safety. The -- and yet, the Worker's Comp issue just doesn't seem to be affected by that, that much.

One of the other things that I have found in looking into the Worker's Comp issue is the presumption that the employee gets help has been used as kind of a legal tool and so then the legal costs become kind of a significant part of that as well. So it's not just the healthcare delivery, but it's getting to the healthcare delivery through this very contentious process that has lawyers on both sides.

I think that is one element of the cost that is going to be hard to get to. So as we have talked about it in the

Legislature is how do you get the rules clear enough that the ambiguities are lessened, and so that's the comment that I want to make.

The other thing is on your estimation of getting tourism or looking for places where you can get care cheaper, there is the lost time for employees to travel, even for significant -- so has the lost time for say getting appointments in this area been as near significant or not to the cost of travel? So to me, that would be one of the equations. If you have somebody out of town for 15 days, but you save $15,000, or you can't even get them in here within the 15 days, I was just wondering if the lost time issue had even been in the equation.

MR. REDMOND: That's a very good question. Sometimes those people, though, are not productive already. So I would say -- I haven't, personally, looked at that, but quite often, if they are requiring care that's taking them out of state, or you know, or they're staying in-state for a major medical procedure, they're already not productive.

MR. HARWELL: The only thing I've seen as far as the inability to get appointments in-state is more of these psychiatric care or psychological care evaluations. We had an instance several years ago, we couldn't get to a psychiatrist for three months to do a return to work evaluation for a person that we thought needed that type of an evaluation. We finally worked around and found someone, but that's the only

thing I've heard about.

The out of -- the tourism issue for me is, that you know, we all know, I think, that we heal better in our own home in our own community with our own support network and we, like I said, the US Doyon Universal has not sent folks down, but Doyon Limited has. In fact, our benefits manager had -- went out himself for -- or his family member did and I -- "How'd that go." He said, "It was great, went down to Seattle, you know, we took the kids and had the procedure. We had a long weekend and we came back home, you know, and everything worked out fine," but that was, you know, a short-term procedure type, and I think it was mainly the cost, the copay cost. So yeah (affirmative), I haven't seen the problem here in the state that I've heard about, as far as being able to get appointments or get the care you need.

REPRESENTATIVE HIGGINS: Yeah (affirmative), this is Pete Higgins again. You know, I Chair HSS for the state in the House side and so, you know, Representative Olson, we've -- we had that Workman's Comp bill that we ran and that was a first bite at the plate, and we did pretty good with that, and we know that Workman's Comp is an issue in the state and we recognize that and we're working on that.

So it was a formula-driven process that was out of alignment with the rest of the country. So now we're going to try to get the fees more aligned. For that, fees will still

probably be a little higher than the Lower 48, obviously. I mean, this is just the nature of the beast. This is where we're at.

So the question that I've got though, because this medical tourism issue's the one that's kind of been hanging over our heads for the last few years, is that -- now, I understand our hospitals are at 38% higher than the national average. What average are you looking at to cut it down? I mean, what are we -- what's our target that we look at? Do we look at cutting our, you know, are we at 10%? Would that stop it? Twenty percent, would that stop it, or can we stop it at all?

The second question is, you know, right now, you guys are going down to the Lower 48 for medical treatments. Well, heck, I just talked to a guy last week that went to Belgium and got it done for hardly pennies on the dollar. So are you guys going to -- are we going to eventually not even go to the United States with our -- I mean, if that's -- I mean is this money-driven or is it just we're looking for services?

I mean, I realize that we live in Alaska. The cost of living here is expensive. Hospitals have to pay more, because of just what it is. So how do we address this medical tourism, because it's really on the forefront of a lot of medical professions in the state and we need to address this issue.

MR. HARWELL: Yeah (affirmative), I can't answer your question on the percentage. I would think it's some formula related to the cost of living. If it's, you know, if we're five or 10% higher than Seattle or 15% higher, whatever that number is, I mean, again, we expect people to earn a good living, but the medical tourism issue, I was at our national HR conference, which is the Society of Human Resource Management, last year, and I don't know, I would guess 400, 500, 600 vendor booths in the exhibit hall, a fourth of them were medical tourism booths, primarily South America and Mexico.

I mean, these are folks sitting there to -- talking to us, HR professionals. Here's the -- you know, come to Acapulco, go to Cozumel, or wherever and get your dental work done, or you know, and it was mostly south of the border, and the costs were unbelievably cheap. The quality of care, I'm not sure of, but the costs were unbelievably cheaper than what we have here, clearly.

MR. BOROWSKI: I think, obviously, that's true, and so I think that my perspective, there's probably no specific number. It's going to be whatever's materially different. I mean, whether it's 10 or 15%, I don't know, but I think most people recognize that Alaska is more expensive, but I think most people want to stay in Alaska.

So I think there's this bias. Alaskans want to stay in

Alaska for the healthcare, if all else is equal, and so to your point, we can't forego the issue of quality and so I know our administrators -- when people are going to leave, they look at quality. That's why people don't just go to Seattle, just because that might be the closest place. That's why we end up sending people, you know, on to Phoenix, on to Minneapolis, other places.

So I think there's a balance. I'm not sure what that exact balance is and ultimately, it comes to both. I think it's neither one, nor the other. It's both, and then, I guess, I'll just share another thought about all this dilemma, and I use the word dilemma, because that's kind of how we've talked about it.

You know, how do we create a win/win environment here? We recognize that people come to provide healthcare services. Either they've come from out of state or they come back to state because they know that they can do well. Let's just recognize that. So how do we create a win/win situation here with healthcare providers, especially those in the specialty networks, so that they can do well, but not take it off on the backs of the many, many employers and employees. So that's the balance, is how do we create this win/win? How do we manage this dilemma, and that's the spot I haven't figured out and that's where, I think together, we've got to figure it out.

MS. ERICKSON: Yeah (affirmative), don't -- go ahead, Representative Higgins.

REPRESENTATIVE HIGGINS: If you don't mind, you know, one of the things that was said there, and this is a problem that the whole state has, and that's a perspective of who we are, and when I hear, that you know, the quality of care -- we have some of the best docs in the world here. We have some of the best hospitals in the world, too, and some of our best facilities that I've been, and I've been all over the states, and so you know, when I hear the argument of quality of care, you know, I look at that and I go, "Well, that's our fault for not getting the word out that we do have that here," and so quality of care, you're not going to find it any better than here. You're not going to find any better quality of care in Seattle, by any means. You're going to find cheaper, but not quality of care, and so when I hear someone talk about quality of care, that just kind of raffles me up a little bit. It's like, "No, no, no, you can't get that, because we do good here," and that's just my two cents for us. Thanks.

MR. REDMOND: I'll agree with you to a large extent, however, I think some of the Worker's Comp, a claims adjuster might argue with you a little bit, but I won't go there, but I'll just speak from personal experience. I had to have some knee surgery last year and I had the option of taking advantage of a medical tourism benefit, and you know, I'm a

local boy. I wanted to do it here.

I found a doc, who I grew up with his family members and trusted him, and it just so happens that, I mean, that's who I wanted to use, but I was really considering going elsewhere, however, just before I was making that decision, he decided to come in network into our Premera plan and I thought, "Hey, that's pretty cool." So I had the procedure done and the first time around, it didn't go so well, and so you know, I was going, "Hey, you know, this thing still hurts." "Well, it shouldn't hurt." I go, "Yeah (affirmative), well, it does." "So maybe you need another MRI." I go, "Yeah (affirmative), how about that." So we did that.

Anyway, again, maybe it's because of the family relationship, those types of things, but the guy warrantied the work. I mean, and again, this is because of the local flare that we have here and the quality of life issues and that's why we attract people with talent. We like living here in Alaska and we want that to happen.

Anyway, he was a good guy. I still had to pay for the second surgery at the operation center, but I didn't have to pay for his services again, and the second result was great. So those are the ways that we can work together to kind of control these costs, but you know, I had the option to go somewhere else where it was a lot cheaper, but my comfort level with that was not great and so I chose to stay here.

CHAIR HURLBURT: Well, I think one of the things, Deb has a question, the Health Care Commission has been pursuing, in addition to getting more transparency on the cost data is getting transparency on quality and on outcomes data, so that can be compared. There are going to be some things that can't be done in a state with 3/4 of a million people.

We're, you know, in probably none of our lifetimes will we see a major transplant center here for solid organ transplants and so we want comparative cost data. It is good to go to University of Washington? Do you want to go to Mayo? Do you want to go to Stanford or the University of Pittsburgh or whatever, for a major organ transplant, but we should -- for the things that are done here for payers and for the consumers, we would like to get the quality data.

In terms of the comparative costs from what Bill Popp said and from the Milliman data, primary care medical specialities, like family medicine, like primary care internal medicine, dental services, those kinds of services where they all seem expensive to us today, but in terms of absolute number of dollars and a cost of a trip to Seattle or San Francisco, it absolutely doesn't make sense to go outside.

Those kinds of services are more like 40, 45% higher. Now, maybe that's too high. Maybe they should be lower and it's all just a swag or a guess. I guess 20, 25% higher here, probably would say that's reasonable for Alaska, but the --

what's driving it are not the dental services, not the primary care services, but the interventional kinds of things that are real expensive and that's where the differences are more the 80 to 90%, and then anecdotally, sometimes several hundred percent higher.

So the routine, everyday care, the kinds of things that keep people well and keep them healthy, I think we're -- the costs are a concern. They're a challenge. They're a problem, but they're not driving people away from Alaska for what it would cost to go elsewhere. Deb, you had a question.

MS. ERICKSON: I actually have a two-part question, and I want to remind Commission members and direct you behind Tab 2 in your notebooks. One of the things that the HR Leadership Network asked us to do over the summer was to provide some information on the policy recommendations that the Commission has made that would require some sort of legislative action, because they wanted to help move some of these recommendations along, and so there's a letter from Dr. Hurlburt dated August 5th that was provided to the HR Leadership Network that laid out five areas where we have recommendations that would require legislation.

A couple of these, I know Florian had mentioned as an area that they're particularly interested in, is transparency, and they're -- we have four other areas, Worker's Comp is another one we've talked about, and we'd also identified that

another issue where we have a recommendation that would affect regulation is related to insurance market and we've been talking about, and I keep hearing the issue of specialists out of network being, I think our Milliman study documented that the prices for those services could, sometimes for certain procedures, be four or five times what they are in Seattle, so those real outlying procedures, and we've identified issues related to the way our insurance market regulation and certain laws take away some of the negotiating levers that insurers and other payers might otherwise have.

One of the things the Commission worked on this morning was, you know, what can we do as a next step to start facilitating action around some of these, and Bill mentioned before he left, that some sort of convening of stakeholders around some of these questions would be helpful.

So it -- the first part of my question is, do you have any specific recommendations of what you think the Commission could do next that would be a little more action-oriented beyond the studies that we've done that led to these recommendations and then the actual recommendations, something that you think the Commission could do next to help, and then the second part of my question is, we had a presentation that we did jointly with Commonwealth North this past year, where we had a woman, who was a head of a business coalition that focused specifically on health, that brought together business

leaders in their community, in their region.

She was from Tennessee, but most states have at least one regional, if not, a statewide business coalition for health, where the business leaders have come together, as you have now, and formally -- more formally, to start, actually leveraging strategies, aligning purchasing policies and those sorts of things.

So I was just -- the second part of my question, beyond what more could the Commission to do to help you around some of these areas? Is it something that you have talked about with the HR Leadership directors about formalizing your network a little bit?

MR. BOROWSKI: We haven't thought about it, but that would probably be an outstanding activity and frankly, I think one of the things the Commission could consider is creating an opportunity to engage, not just your HR leaders, but your CFOs, who are responsible for the financials of the businesses and the organizations, both public and private, to gather together and create such a coalition. So I think that if the Commission would have the interest to be able to host such a gathering, it would perhaps create some additional momentum that this informal group took on.

It was really just a result of our own selfless interests in the areas that we're responsible for that did this. So the space is open and we would certainly be glad to participate

and support such an activity, if the Commission were so inclined. I pause to my colleagues.

MR. REDMOND: I know our CFO would do it.

MR. HARWELL: Yeah (affirmative), and it's a good point. In our company, the benefit administration sits under our CFO, not under HR. So it's -- I don't know if it's like that at several other companies, as well, but I think I agree with Florian that we need a -- perhaps a day, half-day seminar and bring together all the players and have some frank discussions, possibly with, you know, some outside leader to guide us through, both, you know, providers, employers, CFOs, healthcare professionals, insurance companies, et cetera.

I think, I mean, we would certainly be interested in participating in something like that, but as far as us becoming formal, you know, it takes time and energy to make a group and we all have other things -- and we already have, you know, we have an HR group, and we're -- most of us belong to SHRM, the Society of Human Resource Management.

We have an Anchorage chapter. There's a chapter in Fairbanks, but that's more -- I guess it deals with a number of issues, and it's -- this group is more, I guess, more senior than that group, I think, just because we're older and retiring soon, and I think we just saw a focus for that, for this issue and these efforts, because it's just so key to their bottom line, frankly.

CHAIR HURLBURT: Okay, I think we're a little over our time, but Rick and Florian and Tom, thank you very much for coming. Thank you for sharing with us. Thank you for what you're doing and we look forward to continuing to collaborate together in this big challenge that we have in helping Alaska and helping Alaskans and helping our economy. Thank you.

We'll go ahead and move onto our next session. This is going to be an insurance market update and Lori Wing-Heier is here with us, who's the Director of the Division of Insurance. Deb and I have had the opportunity to meet with Lori a couple of times. She's still relatively new, but getting much less new in the job, but many years' experience in the field, former colleague of Greg's, and knows a lot about the field, has some interesting ideas that she shared with Deb and me. So we'll kind of turn this over to you, Lori, to give us an update of where you are and what you're doing and then maybe have some chance for some questions and discussion.

MS. WING-HEIER: Certainly, thank you, Dr. Hurlburt. Thank you for having me, members of the Commission. Some faces I haven't seen in a long time, but others, I've seen more recently, Senator Coghill, Representative Higgins, and others.

Well, I went from basically being an unknown in this state to being recognized on the street corner as the -- as pretty much that, it would -- and you know, we certainly have

been fairly busy and very active the past month, in particular.

We knew in late summer that when the rates were released, we weren't quite sure where they were going to fall yet, but we knew that the experience of the insurers.....

MS. ERICKSON: Linda, can I interrupt for just a second, I'm sorry. Could you speak right into the mic, because there's a lot of people on the phone and they can't hear, unless you sound really loud in the room.

MS. WING-HEIER: Sure. We knew in late to midsummer, in looking at the data that had been provided to us by the insurers of those that were offering insurance under the ACA, that the results were not favorable. So it became a question of how, you know, what can you do to still meet the intent of the ACA by having insurers on the exchange?

Certainly, there were concerns with the insurers if they could afford to continue on the exchange and we are very glad that both Moda and Premera are going to continue to underwrite insurance for individual and small group markets in the state of Alaska, and we see that as a win for us and we see it, certainly, as a win for the consumers in this state.

There is no doubt that when they approached us in the summer, that there were conversations of how high the rates would need to go, and we, as basically the guardians for the consumers of the state, are held to approve rates that will

meet what the expenses of the claims are, and there could be a very strong argument that the rate increases were perhaps not enough to be what we would determine adequate, but when you look at a period of time and when you look at the financial strength of the two insurers, we were comfortable in where we ended up with numbers, feeling that they could sustain to take, keep their programs in the state of Alaska and in the cases of Premera and Moda, we know that the data still indicates that they will have a negative loss of somewhere close to five million, in Premera's case, in 2015.

If it were a company that did not have the financial solvency, that did not have the capital behind it, it might have been a different story.

There's, you know, certainly a message that we've been trying to convey and it has perhaps been missed by some, that the individual market has gone up. There is no doubt, and there has been a lot of talk about the manner in which we review rates, the process we're held to, the statutes that we're held to, the guidelines we use, the data we get from the insurers.

We use that same process, those same guidelines, those same statutes, the same everything, and the small groups are going down and nobody's saying a thing to us, but the small group markets are going down. I should say, Premera is actually -- or Moda is actually decreasing about 3% and

Premera's small group market, it is an increase, but it's just at 5%.

So it did have better experience than the individual market and we believe that the individual market had a couple of things. Certainly, we had some claims of insurers that came in that we think they did not have insurance to begin with and there are some very sick people in that pool and we can tell that by looking at the diagnostic codes.

For a long time, we went back and forth between pent up demand and very sick, and this is not pent up demand being, I finally have insurance. I want to go have that physical. I want to go have the dental. I want to have all the things I couldn't afford. These are very sick people in the plan that are causing the claims and they certainly have the right to be treated and they are being, but it is expensive. I've heard you talk, you know, about the cost of healthcare and it's the cost of healthcare.

So anyway, to get back to my point, yes, we had some adverse loss experience in the individual market. There are about 16,000 people in the individual market. There has been some talk of how many would be in the individual market if everybody enrolled and the best we can find, because it's hard to pull that number of how many people exactly would be put into this pool, it would be somewhere around 21,000 to 22,000, depending on what study you look at.

So even if all 21,000 or 22,000 enrolled, it might bring the rates down some, but we're still -- we're not missing 80% of the uninsured population. So I do want to make that point, because there has been concern that we have not reached the uninsured market to enroll and there are probably some that we have not reached, but between the Division, between the state outreach programs through the Commission and others, certainly through the navigators, the CACs or the certified -- they're -- the majority of the state has been touched and knows that the Affordable Care Act is available.

It's just getting people to enroll and some people, for whatever reason, they have not enrolled and we are going to continue to pursue getting the message out there for people to enroll.

We are also targeting a message to the -- those that are in the pool right now or in the FFM, that there's two insurers on the exchange, Premera and Moda, and that's what we hear about, but there are actually five insurers that are offering insurance to the individuals.

Now, what the issue is, is that if you qualify or are in need of a subsidy, then you need to go to the exchange to get that subsidy, but if you are a part of that 6,000, of again, the 16,000, 10,000 on, or a little -- about 10,000, that are on the exchange getting subsidies, 6,000 that are not receiving subsidies, those 6,000 can shop their insurance and

we've done some comparisons and if you take a Premera Silver in 2014 to a Premera or a Moda Silver in 2015, it's about a 13% increase.

So if the consumers think and don't -- I mean, the onus is on them. They are going to have to get into Healthcare.gov or work with a broker or a navigator or what have you, but they're going to be the ones that have to make that change from one insurer to another.

So we're encouraging them to shop. We think that Premera has a big name out there and in the beginning, a lot of people felt more comfortable because of the Premera name, and they may still elect to do that, but there are options, but the consumer needs to shop their insurance and see what is the best company.

Aetna, Assurant, Celtic, they're all writing individual plans and we are trying to message to -- for the insurers to -- or for the insured, the consumers, to shop their insurance and don't just automatically renew.

There's also been some confusion in the market regarding Moda, and Moda is writing individual plans in 2015. The elected not to extend the non-grandfathered, or those plans that we call the transitional plans.

In late 2013, when the governmental website was having its issues with people getting enrolled and there was -- the message from Washington was if you like your insurance, you

can keep it, and it wasn't exactly rolling out that way. The federal government allowed the states to individually either accept the transition or we, in our case, what we did, was we allowed the insurers their option to cancel the policies of their insureds, rewrite them, effective December 31st, 2013, and that would carry them through December 31, 2014.

Premera and Moda took us up on that option. So they are the only ones that have in this state, what we call the non-grandfathered or the transitional policies. Moda has, in that group, 855 individual plans. They have elected to not keep those as non-grandfathered plans and are reenrolling those people in ACA compliant plans, but they are not -- they are not dropping them from coverage. These people are not out of insurance, but they are going to go from a non-grandfathered plan to an ACA compliant plan.

The other issue, which is bringing some confusion to the matter, is when the forms were filed for Moda in 2013, CMS reviewed them in 2014, and said there were a couple of concerns with the language in the form, and those concerns had to do with a coinsurance and a deductible and the pediatric dental.

They came, and there were conversations back and forth, and they basically said, "You're going to have to cancel those plans and rewrite them on new policies that comply with the ACA in these two issues." So Moda has proceeded to correct

their forms for 2015, and has sent notices to their insureds that this policy is being canceled and they will receive a new policy. It will be very transparent to them, that is fully compliant with the ACA, as respect with coinsurance, copays, and pediatric dental, but they are not dropping those people. They're just being renewed on a different form that is compliant with the ACA.

So we are hoping to get that message out to people, because there has been confusion as respect Moda. They are not pulling out of the market. They just have two segments that are being treated a little bit differently, and again, when these people, they have the option, when they get the notice from Moda to shop it and see if there is yet a better deal than Moda for them on the market.

Okay, have I answered everything on ACA you wanted to know or -- I did want to talk a little bit about something that has hit the paper today that we are watching. There's a couple of things that we're still watching. One is how the courts will, at some point, determine the subsidies. Right now, it's kind of a mixed bag. There's different court opinions on if subsidies are legal, the -- or the tax credits, for those that are on the exchange, those that are of lower income, have applied for subsidies. It's basically a tax offset to -- for their premiums.

There's court rulings that say their legal and there's

court rulings that say they are not legal, and these address those that are on the federal exchange, not so much state exchanged, but federal exchanges, and we are watching that closely, because we are on the federal exchange, to see what the final determination will be, because certainly, we would have 10,000 to 11,000 people that right now, 88% of our -- those that are applying for the Affordable Care Act are receiving subsidies and they would need to be addressed at that point as to how they could afford to pay for the insurance, I mean, they're being -- they have to, by law have it, but if they can't afford it, if they're being subsidized now and the subsidy's taken away, we're watching that very closely and to see what can be done at that point, and we don't have an answer, but we will continue to monitor it.

There was also that the GAO came out today and said that the risk corridors in 2014, which is a federal program that -- it's an assessment or that the insurers pay into to basically even the losses amongst each other -- each other, and the GAO's come out and said that it is not legal, that in order for it to go forward in 2015, it's going to take congressional appropriation.

MS. ERICKSON: Is that the reinsurance program, the federal reinsurance.....

MS. WING-HEIER: It's the risk -- it's the risk corridor, the three Rs, yes. It's a.....

COMMISSIONER MORGAN: Can I ask -- may I ask a clarification question? I thought there was the reinsurance -- I guess I've been totally wrong for two-and-a-half years. I thought there was two portals. There was the reinsurance one and then there was one that was basically a guarantee via the Federal Treasury to cover whatever the insurance companies -- when they evened up the books, to cover those losses to make them whole. Now, have I got -- I must have that wrong, but I was -- what I'm hearing down here is that.....

MS. WING-HEIER: The risk corridor is -- it's limits the insurers gains and losses, and it is subsidized by the federal government. The funds come from the government and what they are now saying is that will have to have congressional approval to go forward in 2015.

COMMISSIONER MORGAN: It's a budget thing. They have -- if they -- when they balance the books, and boy, do I love that word, balance the books, and let's say, they need $100 billion or something to balance this sucker out, then there has to be an appropriation, because one Congress can't bind another Congress on fiscal matters, they will have to put it in the budget, just like buying a boat, a B-52, and say, "Here's the money to go into the fund to even out the books," that's what we're talking about, right?

MS. WING-HEIER: Yes, sir. I do believe that is correct, and right now, what we are -- what we were told is that it has

not been addressed for 2015, and that it will have to go -- it will have to be approved by Congress for 2015. So we are monitoring that to see what the response of our insurers are as we go forward.

I don't think it will stop anything for 2015, but it could certainly impact something for 2016, if the Congress were not to reappropriate the risk corridor.

MS. ERICKSON: Lori, did that -- did the risk corridor for going into 2015, did that help mitigate to a certain extent, Moda and Premera's premium increases? Would they have been even higher without that?

MS. WING-HEIER: If it had never existed, if any of the three Rs had never existed, my guess is yes, but part of the issues with the three Rs, and what the insurers will receive from the federal government, from the reinsurance, from the risk assessment, the corridor, or the reinsurance, is it won't be paid until '15, so they basically have to close the books for '14 to be paid in '15, and they don't know yet what to expect.

Part of our conversation, originally, with the insurers, what -- they were antsy because as Mr. Morgan has pointed out, everything has been, you know, said it's going to be budget neutral and the insurers were, it can't be budget neutral. Now, maybe it -- I'm not in D.C. to say one way or the other, but there has been a lot of conversation, if the program can

continue as budget neutral, and if it can't, then how does -- if you were to receive 80%, are you only going to get 22% or whatever the number is. Mr. Morgan.

COMMISSIONER MORGAN: Yeah (affirmative), it's Dave, you know, that's my dad. That's my -- Dr. Morgan in Lexington is Mr. Morgan. I ask Congressman Young about this at another activity and I got a real sketchy answer back about the feeling of Congress on this issue, of -- he said, "Yes, there will have to be an appropriation bill," and it's -- that's where it stopped exactly.

The other issue is how can insurance companies even plan rates when they don't have this information, and how can you, as an individual, trying to, in good faith, regulate an industry, how are -- what -- okay, never -- a lot of Excedrin, is that where we're going here?

MS. WING-HEIER: And others, but I -- it's -- part of the -- you're exactly right. In 2014, the assumptions were made based on what the insurance companies, not just in Alaska, but everywhere, thought they would receive in the pool, how many healthy individuals, how many sick individuals, how many people total, what the ages would be, where they would live, where they'd receive medical treatment, how much of them would use the insurance immediately, because they were sick, how much of them would use the insurance just because they'd been putting off primary care?

So it was -- it was guesses to anybody's -- anybody would tell you that. Going into '15, we're in a slightly better state than we were, but still, there is a lot of unknowns. When the '15 rates were filed, we had claims data, basically, for six months to look at, and any statistician would tell you that is not a good number to start with, as far as data, to predict into the future, based on the past six months.

Now, we're in a little bit better position, because we at least have the six months. So we're a little bit better than we were, but it's still not a perfect scenario. So any state regulator would tell you that when you're looking at rate increases or decreases, but looking to approve rates going forward, there is an element of trusting your instincts as to what is out there for your population and what the cost of that population will be.

COMMISSIONER MORGAN: I guess my last retort in all of this, everybody else is sort of looking at me like, "Are you kidding me? He keeps asking all this stuff." My last retort, couldn't -- couldn't we, not us, personally, but couldn't our congressman or one of our two Senators simply put in a binder, a bill, one sentence saying, "Holy moly, macaroni, it doesn't matter whether it's a state exchange or a federal exchange, but if it's a certified exchange by Health and Human Service, the subsidies count," and -- because basically, what we're doing is what I call lawyer talk, splitting a hair, yeah

(affirmative), the law said, "Federal exchange," but you know, it's a 2,000-page law, somebody didn't put a comma in or an and, and put in -- they all assumed everybody would have their own exchange, like they assumed everybody would expand Medicaid.

Wrong. They didn't do it, but couldn't you just -- couldn't Congress just solve this with a one-sentence amendment or bill that says, "Hey, it doesn't matter if it's a federal or a state, and it's certified by Health and Human Services as an exchange, you play in this," and then -- and that's skips that stuff because now, we're starting to talk about a whole segment of an industry that could go into bankruptcy if we don't straighten this out.

Whether you're for it, against it, neutral, don't care, I don't think anybody wants Aetna to go to the Federal District Court for bankruptcy. I don't think that would help the general economy in general, and statisticians that I've talked to, you actually need four or five years of claims data to really do a good rate. So this is getting kind of, you know, as my surfing buddies used to say in Florida, we're kind of out on the edge and the rip tides coming in or if I'm totally wrong, please, tell me I'm wrong. I'd love to hear that.

MS. WING-HEIER: As far as working with Congress and getting a sentence in or out, I'll leave that to the Senator Coghill and Representative Higgins to tell you if it would

work and how you would get it done, but there -- there are some aspects of the ACA that we think would possibly help in it.

You're doing single -- these pools of little to no underwriting and certainly, the intent and the benefit of the ACA is that everyone is entitled to insurance and therefore healthcare, which is a good thing.

The issue is that we're -- we've crippled, in some ways, the insurers from being able to underwrite in the way they were before to assess if you're a high risk, as opposed to not, and certainly, that's presents its own set of issues, because prior insurance was available, but if you were ill, had a significant condition and illness or such a chronic illness, then you certainly paid a higher premium, and is there a better way to distribute this out? I don't know. We're certainly looking at everything we can to look at how to provide insurance to our consumers.

One of the things that the ACA does that is troubling to us, when you're looking at losses such as in 2014, where the losses have been adverse, and in some years, I can tell you that the insurers were paying out a little over $2.50 for every dollar they took in, in premium, and any business cannot survive when you're paying out that kind of money.

It just doesn't work, but there is this, what they call, it's a medical loss ratio, and if you're insured, when we're

talking, guessing as to what you're -- who you're going to be insuring and what the claims are, and if you guess wrong, as the claims are more than you anticipated, then the insurance company is required to still pay it.

Now, there may be some adjustments coming from Washington through the risk corridor and the risk reinsurance and such, but nonetheless, they -- those programs will, at some point, phase out and they are required to pay the claims.

If they guess right, and the claims are less, and I'm going to do this as right and wrong to simplify it, then they are required to give back the money. Well, when you go back and say, okay, I had two bad years, but I had six good, and so I can spread this out, you can't do that anymore. It's called the medical loss ratio and you'll hear it as the 80/20, and you will see that in -- if you remember back early summer, there was a big article in the paper that Premera was writing checks out to the people of Alaska, and you know, they were getting back a few hundred dollars here and there, because the medical loss ratios, they had guessed high. They had guessed that their claims were higher than they actually were and they ended up having to give the money back.

Well, this is part of the ACA. So there's no savings account for an insurer and it's a year-to-year. It's not that they get to look at 10 years of what -- and settle up or true up with the insurers then. It's a case-by-case, year-by-year

basis. So they don't have a savings account to say, "You know what, '13 was a good year, '14 was bad, '15, you know, what 18% would do it. We're still looking good."

No, they're underwriting year-by-year, because on their good years, the money is going back, and as you were pointing out, you know, nobody wants to see Aetna -- we can't afford to see the insurance companies fail for numerous reasons, but there are some different underwriting rules for the insurance companies that have changed the game for them. Yes, ma'am.

COMMISSIONER ENNIS: You know, part of the solution, of course, is increasing enrollment substantially, and we know that would include increasing enrollment of healthier, younger people, dramatically, and that could help things begin to balance.

There are a lot of challenges I hear, but is there anything the Division of Insurance could do or you would like to do or recommend to assist in enrollment, and perhaps, you could just talk a minute about the messaging that you do, but are there other strategies that the state could undertake to promote enrollment?

MS. WING-HEIER: We have met already with Alaska Primary Care Associates, who is one of the new navigators and discussed with them, basically an open-door policy on working with them as they're delivering the message out, particularly to the rural communities. We were concerned when we found out

that ANTHC was no longer going to be a navigator, simply because we were concerned that there would not be a resource available to rural Alaska. In meeting with them and with United Way, our -- we think that our fears have been somewhat lessened, that they are spending a significant amount of time and money in developing their plans to get out in outreach programs.

We are doing some messaging on our own, on our website, in the paper, and other -- I've had so many speaking engagements, I can't tell you, to talk about people enrolling and to get the message out, to find those that we think are missing from the enrollment.

I don't know what else we can do, other than work with the insurers, work, certainly, with my counterparts in the state, working with the Health Commission and with the navigators to get people into enrollment, but we're doing the best we can to get them to enroll, because I agree, the more we have, the better off we will be. We think, in theory, the larger the number, the better it should spread the risk.

COMMISSIONER ENNIS: Thank you, and then of course, the more we have enrolled, the more we have that are insured and will get healthcare. So it's a win/win situation. Thank you.

MS. WING-HEIER: A couple of other things, I know that I have a limited amount of time, I will tell you, you've had conversations today about Worker's Compensation, and on that

front, we're looking fairly good. We're actually going to take a decrease in our rates of about 1%. So it's almost flat for us.

We're finding that the frequency is going down, meaning that there's less claims, however, severity tends to go up, and severity, it doesn't necessarily mean what happened to the person. It's the cost of the claim, to us, that's severity. So frequency going down, as far as number, severity, cost of claims is going up, and we have certainly heard from Representative Olson and others of what -- how the Legislature will be looking at Worker's Compensation in the coming year and I think that Representative Olson, that is key on his agenda, as addressing Worker's Compensation again. I don't know what he has planned. I just know it's on his agenda.

I recently met with some counterparts, and this is something new, and I haven't had a chance to talk with Dr. Hurlburt or with Deb and it's long-term care insurance, and it was a product that came out about relatively 20 years, and it was intended more for the middle class and lower income, and it was a way to look at not having to basically down-spend to qualify to have your Medicare pay for long-term care of (indiscernible), hospice care or what have you.

The policies were cheap and again, we're looking at an insurance company or companies predicting what the future is and we're finding now that for the claims or the policies that

were written between 2000 or 1992 and 2012, the cumulative claims are 76.6 billion dollars in long-term care and that's on 262,000 policies that are currently in force.

Now, Alaska, we do not set the rates for what Alaskans pay for this. It is -- I'm not -- I don't know that I can really tell you why we haven't, but I can tell you that Alaska, it's not within our authority to set the rates for long-term care at this point, but we are watching the trend, because they are saying that if all these -- the policies that have been sold, were to file claim, be paid the maximum under the claim, you're looking at close to two trillion dollars in long-term care, and there's not enough money in those policies to pay out two trillion dollars.

MR. PUCKETT: (Indiscernible - too far from microphone).

MS. WING-HEIER: No, this is nationwide, sir. So it's, again, it's something we're watching to see if -- I've heard of different, perhaps it's going to end up being a partnership between Medicaid, states, federal, insurance companies, to look at how we're going to address long-term care insurance, and allowing, I mean, certainly, if you have the means, you're not buying this because you know how you're going to pay for -- when you're an elder or when you're at an older age and need at-home care or possibly a nursing facility of some sort.

So again, it's more -- these products were designed more for middle class, for lower income, and the popularity of

them, I believe has exceeded what they thought the demand would be and certainly, the claims have exceeded what they thought the demand would be.

CHAIR HURLBURT: So if the at-risk entity, the insurer has to default, goes bankrupt, whatever, because the claims and the liabilities so far outstrip their reserve, does that mean that the liability would then revert back basically to Medicaid, because if it's -- if it's the less affluent or even the middle class folks, they basically will run out of money doing it themselves?

MS. WING-HEIER: They will run out of money, and it could, in effect, revert back to Medicaid. It also -- the other side of that is it could be the guarantee association of the individual states, which in -- and there -- it is not probably taking into account the impact that will have. It's something we're looking at now. The question.....

COMMISSIONER HIPPLER: Not on this topic (indiscernible - too far from microphone).

CHAIR HURLBURT: So that would be state government?

MS. WING-HEIER: The state has two guarantee associations, one for property and casualty, and one for life and health. In my lifetime, we've looked at the property and casualty on a couple of different occasions. I'm sure that many of you will remember the industrial indemnity Fremont, and then Kemper, when they went into liquidation and that the

associations then paid out the claims, and they are -- the issue with the guarantee association, it's a set amount per claimant. So it's not, if you bought a million-dollar policy, that you'd get a million dollars. You would get what the guarantee association allows per that policy, which is dictated by reg.

CHAIR HURLBURT: But it would be paid out by the companies and the industry. It wouldn't become a liability of government?

MS. WING-HEIER: No, because in essence what happens, is the guarantee associations are funded through assessments back amongst the insurers.

CHAIR HURLBURT: So Alaska's share would be four or five billion, something like that, probably, two trillion?

MS. WING-HEIER: I don't know, Dr. Hurlburt. I would have to research that more.

CHAIR HURLBURT: Just doing population numbers, yeah (affirmative), but a significant amount of money, yeah (affirmative).

MS. WING-HEIER: It's -- there is a significant amount of money in these and the issue is now as to quantify where we're at, how many people have purchased these policies and how the insurance companies are looking at them in Alaska.

We had received some criticism last year, and I shouldn't say criticism, but some concern because the rates had gone up,

but again, we don't -- we don't approve or disapprove their rates, and we are now taking a closer look at those, just to see what they are charging people and if the rates are justified.

Again, I don't have the authority currently, to do much about it, but I would rather be proactive on it and looking, so that if these claims -- if there is not enough money to pay claims in the future, we're addressing it now and dealing with the insurers now, to make sure that the claims, the money is there to pay the claims, but I think it's surprising, the amount of money that they're saying, if maximum potential would be paid under long-term care policies nationwide. Two trillion dollars is a lot of money.

MS. ERICKSON: We should probably -- we only have five minutes left. So Allen, do you want to go back to the question that you had earlier, even if it was an earlier topic?

COMMISSIONER HIPPLER: Sure, thank you. We have 16,000 people in the individual market roughly, is that correct?

MS. WING-HEIER: Yes, it is.

COMMISSIONER HIPPLER: And how many did we have prior to the Affordable Care Act implementation?

MS. WING-HEIER: I am going to say we had about 5,000 in the individual market, but I am guessing. I can get back to you with the exact number on that.

COMMISSIONER HIPPLER: Please, and you estimate an actual population that is -- an estimate of the total population of 20,000 to 22,000 people, something like that?

MS. WING-HEIER: That is correct.

COMMISSIONER HIPPLER: Okay, and the Moda plan, there's 855 people grandfathered and Moda has chosen not to continue the grandfather of that plan, which means that that's going to transition to an ACA compliant, and presumably, much more expensive plan?

MS. WING-HEIER: Yes and no. Those are non-grandfathered. If you look at -- and this is how we define it, people that had insurance March 23rd, 2010, you've had insurance forever, those are grandfathered plans. They are grandfathered until there's some significant change and they have to become ACA compliant. Otherwise, those plans can churn along until ever. They are truly grandfathered.

Those that were written March 23rd, 2010, to January 1st, 2014, those are the non-grandfathered plans. Originally, the intent was that they would become ACA compliant and then with the cost and the issues of the website becoming ACA compliant, they became non-grandfathered and transitional plans, and those are the 855 that Moda has that they are not going to renew. They will go to ACA compliant plans and I dare to say they will be more expensive for those 855 consumers.

COMMISSIONER HIPPLER: Thank you.

CHAIR HURLBURT: Yes, Robert.

COMMISSIONER URATA: So do you have any recommendations for us as a Commission to recommend to the Legislature, and I'm kind of referring to the statement that you need authority to look at long-term care problems. Is that something that needs to be legislated or can you just do that if some boss tells you to do it, or are you the boss?

MS. WING-HEIER: I don't think I'm the boss. I think what will happen is we will file a regulation and ask for the authority to take a look at the programs, and I don't think it will -- I think in legislation, it's there. It's in regulation that I need to adopt and I (indiscernible), we will ask for that at some point and take a look at the LTCs.

COMMISSIONER MORGAN: Okay, if this blows, let's just say, "Hey, Lincoln, aren't you glad you joined the Commission?" If this blows up, and our middle class when they bought it, but like in all Medicaid and Medicare wrap-arounds for long-term -- for elder care, long-term care, they spend down their assets, couldn't a lot of these end up on our Medicaid after they spend down their assets? Is that what's going to happen? Is that.....

MS. WING-HEIER: That would be my guess, sir, is that we would be in the same position we were before these products were available.

CHAIR HURLBURT: Okay, Lori, thank you so much for coming

and sharing so generously and being so open with us on this. It's very helpful.

MS. WING-HEIER: Thank you for having me.

CHAIR HURLBURT: You bet, yeah (affirmative). I think we're right on time for 15-minute break and then.....

MS. ERICKSON: I'll just make a note that this next session is particularly important now, since you all made two of your six top priorities in our Focus on Prevention section. So we'll have a presentation by Dr. Butler with help from Dr. Hurlburt in 15 minutes.

2:59:40

(Off record)

(On record)

3:18:30

CHAIR HURLBURT: Let's go ahead and come back together. Deb is going to Chair the last session and as -- or the next to the last session. As she was noting, this -- the lead into this was the way the dots went this morning and so we're going to talk about public health and prevention.

Dr. Jay Butler, who was the original Chair of this group, and is now with ANTHC, is, has a presentation. You can maybe introduce yourself some, but Jay has an interesting distinguished career and including time and academia in Atlanta and with CDC. During -- when Jay was with the state, as the Chief Medical Officer with the state, while still an

active duty commissioned officer with Public Health Service and left that during the H1-N1 outbreak and went back to Atlanta again with CDC, during those hectic days when we didn't know how bad it was going to be and what was going to happen and provided national leadership there, but left his family here as an anchor so he could get back to Alaska.

He had then, with CDC with a lab here, and so when that was done, Jay came back and is the Senior Director with the Community Health Programs, with ANTHC, but kind of so typical, we talked yesterday some with the over-the-hill meeting, that one of our strengths is how folks work together, but part of us folks work in a lot of different places and Jay exemplifies that, where he's worked with the state. He's worked with the Tribal Health Program. He's worked with CDC. So welcome, and thank you for coming. You may want to introduce yourself a little bit more, and then Deb is going to Chair this for us.

MS. ERICKSON: Yeah (affirmative), and I actually thought I would start off by introducing the session, because I titled this session a little differently than what I asked Dr. Butler to present to you all, but if you will recall, and for those of you who are new, you won't recall, of course, but a couple of meetings ago, for our Healthy Alaskans 2020 update, Lisa and -- from the state and Emily from ANTHC came and part of the update about the Healthy Alaskans initiative, they shared that they had just hosted ANTHC and the state together, a

community capacity review to -- where they brought 80 individuals together, who had different perspectives and representing different parts of the public health system and stakeholders in the public health system, to spend a full day working through a nationally designed tool that's used for evaluating public health system performance.

That report was just released yesterday and I did not print a copy for your notebooks. I thought they were full enough. I'm going to send you a link to it. The report's a little bit technical, but there is already some good work happening and I expect to see a report from the Division of Public Health, potentially in just the next couple of weeks, starting to share their perspective on the assessment and documenting some of the initial steps they're going to start taking to respond to it and to actually take some implementation steps around some of the weaknesses that were identified.

So I'm going to share both of those reports with you over email, just links to them. I wanted to reflect back, though, we have gone through a public health system assessment and improvement process in the past, about 15 years ago, maybe 10 years ago, but there was a large coalition of Alaskans representing lots of different sectors participating in that process.

The response that we had from the Legislature, one very

directly, and a couple of other a little less indirectly, but still tied to it, that directly led to important improvements in or state's public health system. One was a complete modernization of our state public health laws that had not been updated since before statehood. We now have some of the most modern public health laws in the country at this point, both in terms of science and disease control and civil procedure.

Also, it was around the same time, we had our two new public health laboratories in Fairbanks and in Anchorage built with support from the Legislature, and those were real significant kind of infrastructure improvements that came out of that process and so I'm really looking forward to seeing what comes out of this most recent assessment, but I thought it was more important for this group right now to just take a step back and have more of an introduction, because we've -- while we talk about the importance of prevention and we have a few focus areas that are real specific to obesity, immunizations, behavioral health, we haven't really talked about and learned about the public health system, the way we've had some learning sessions around the behavioral health and long-term care systems.

So that is why I invited Dr. Butler today and you will have some follow up afterwards. One of the things you might be thinking about through his presentation is one of the six

areas you selected this morning that wasn't one of the three that we had our breakout work session on, but it's more -- it was a little more generic, to supporting prevention and what we could do to support health lifestyles.

You might want to be thinking about what you're learning from Dr. Butler to inform what we identify as actual action steps that we would want to take to advance this. Does that make sense? Okay. I will turn it over. Thank you.

DR. BUTLER: Okay, thank you, Deb, and it's good to be with you today. I actually see some faces from back in the days when we were in the basement of the SOB on Saturday mornings. So I'm glad to see that, at least, now we meet on weekdays. So I think that's a sign of continued maturity and the leadership that Dr. Hurlburt has provided.

What I'd like to do this morning, as part as framing the ongoing discussion about the community capacity review as it relates to the public health system assessment, which I recognize is a document you haven't seen yet. It's just now coming out, is basically to paint a collage of what public health activities occur in Alaska.

So kind of starting with very basics, you know, what is health? I've always liked the long-standing definition of health used by the World Health Organization that it is a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity.

I do recognize that the Commission has a vision that Alaska would have the longest life expectancy and I don't -- I want to say that is a good vision, and a good goal to work for, and it's for epidemiologists, it's somewhat technical because we can sometimes fight about different health outcomes, but life and death are usually fairly easy diagnoses to make, as one of the grandfathers of epidemiology once said, "Death is a fact. All else in inference."

So moving then into public health, several years ago, the CDC and some other groups did focus groups, posing that question to Americans, and two things frequently came up. First of all, there was a perception that while public health is free, healthcare, it's the safety net for people who don't have a doctor.

The other was that public health is people you interact with when you have diseases that you would really rather not make public. That particularly seemed to be common among the World War II veteran era, and then there were some teaching about what public health is and I thought in some of the focus groups, the best quote I heard was a Gulf War veteran, that said, "I get it now. Public health has my back," and I think that's excellent.

The discussion that occurred during the system assessment and is in the document uses the Institute of Medicine definition that public health is what we do as a society,

collectively, to assure the conditions in which people can be healthy. You'll notice there's not mention here of government agencies. In fact, if we look at the WHO definition of public health, it defines public health as all organized measures whether public or private to prevent disease, promote health, and prolong life among the population as a whole.

My background is -- my training is primarily clinical. Although, I work in public health. The difference is, as a physician, I take care of patients one at a time. In public health, we think in terms of the entire population. An example would be obesity. I just diagnosed a new case of diabetes this week and someone who's struggling with diabetes, I can, you know, provide advice to lose weight. It's well shown that really doesn't do a lot of good. Medical management is challenging. Bariatric surgery, actually does seem to help in obesity, but of course, it's very expensive and can have a number of complications.

Public health focuses more on issues like education, encouraging food labeling. It's a little bit -- it's not one of the police powers of public health, but I see labeling is kind of like when the cop says, "Do you know how fast you were going?" It's a chance to say, "Do you know what you were eating," and so the people can make those informed choices.

It even gets into areas such as ag policy, whether or not we have ag policies that assure healthier foods are available

to people.

In the document, there is also a definition for social determinants of health. That's a little beyond what I'm going to try to address, but you will hear people talk about things like poverty and education, as those relate to health, and that's moving a little further upstream than we traditionally have in public health.

The discussions that occurred during the assessments were framed in terms of the 10 essential public health services that were defined by the Institute of Medicine in 1988, and I want to touch on each of those during the presentation, but first, I want to talk about who provides these services in the United States, the way our healthcare system is set up, and who in Alaska.

The primary services are through state and local health departments. The, actually 51 state health departments, including the District of Colombia, the eight territorial health departments. There are over 2,500 local health departments. There are also tribal health departments. You know, a lot of tribes are involved in public health. Some of the larger tribes that particularly, are on reservations and have defined geographic areas, such as the Navaho Nation, Cherokee Nation in Oklahoma, have very well developed health departments and really function at the level of a local or a state health department, and then also, federal agencies.

Nationally, CDC has the label of the nation's public health agency, but certainly, other agencies are involved, as well.

Here in Alaska, of course, we have the Department of Health and Social Services. Many of the functions are delivered through the Division of Public Health. We have two local agencies. The most developed is the Municipality of Anchorage, but North Slope Borough also has a public health department.

On the tribal side, ANTHC and my group, the Division of Community Health Services, provides statewide support for public health services to the tribal organizations and the villages throughout Alaska, but also the regions do quite a bit, in terms of public health, and all of this is in partnership, one of the things, I hope I can make clear.

Yesterday, I heard Sally Smith say, "There really are not lines between Native health and non-Native health," and I think in public health, that's particularly true.

We also, I think, have an advantage in Alaska that we have resources from the Centers for Disease Control and Prevention, actually in-state. The Arctic Investigations Program is based on campus at Alaska Native Medical Center, and that has a long history, going back decades.

We also have one of the 12 quarantine stations. There's a very small staff that is based at the Anchorage Airport,

that basically provides that front line for importation of, particularly, infectious diseases into the United States, which is something I think we've been hearing about in the news quite a bit lately, but there's also, outside of government, other organizations are involved in the delivery of the public health services.

Schools and universities and all of these organizations manage large numbers of people and are responsible for their health. There a number of non-government organizations, not-for-profit organizations, hospitals, health systems, health plans, HMOs. Employers are more and more oriented toward population health, another word for public health, as they try to look at how they bring down the costs of healthcare, and that ties into the whole prevention connection that Deb already mentioned.

So I'd like to kind of quickly go through a collage of each of the 10 central public health services. The first is to monitor health status to identify and solve health problems. This is kind of the classic public health surveillance and the reporting of what are, under legal mandate, reportable conditions.

Historically, that's mostly been infectious diseases, but I chose an example here that's not infectious, unintentional injuries. I also chose this because here's a good example of collaboration between ANTHC and the Alaska Native Epidemiology

Center and the Bureau of Vital Statistics, which is part of the Division of Public Health, and it shows a number of things.

First of all, historically and to some extent now, we have higher rates of unintentional injury in Alaska than in other parts of the country. That top line is the rate among Alaska Native people. There are higher rates of unintentional injury among Alaska Natives, but it also tells a pretty good story, in terms of the rates have declined significantly and are about half what they were about 30 years ago. A lot of that is because of intervention in areas related to occupational health.

In trying to solve some of those health problems, I think Hepatitis B is a remarkable example, in that we had very high rates of Hepatitis B, in particularly Southwestern Alaska. If we go back 30, 35 years, we have a technical solution, in terms of the Hepatitis B vaccine. We now have almost no new cases of chronic Hepatitis B, and very few, literally one or two a year, of acute Hepatitis B, and now, Alaska Native people actually have one of the lowest rates of Hepatitis B in the country.

The second is diagnose and investigate health problems and health hazards in the communities. This often times translates into investigations of outbreaks of disease. Dr. Kipp (sp) Bagot (sp) is on top there doing a nasal swab on a

man who doesn't look very comfortable with it, testing of specimens in the laboratory.

There's also a slide here of Dr. Tom Hennessy out at the Anchorage Airport during the SARS response about 10 years ago, ready to greet a flight that came through Anchorage with a SARS patient onboard. I'll say, the bag actually has some smoked Alaska salmon because we knew if this patient was -- would probably be hungry and he's now a high official at CDC and we're waiting for him to give the plug that wild Alaska salmon helped cure his SARS. He hasn't given that testimony yet.

Of course, investigations that are conducted by the state health department are an important part of that, as well. The -- nationally, there's the Laboratory Response Network that is, I think now somewhere close to 70 laboratories that have very specific protocol-based training in diagnosis of certain high -- infectious diseases of high concern, including ebola virus.

We have two of those laboratories in Alaska. These are also laboratories where there's been specific training in chain of custody, so that these are people who can manage specimens that might also end up being evidence, for instance, in investigation of a bioterrorism attack.

Three, inform, educate, and empower people about health issues. This is an area where I think we do a lot in the

Tribal Health System. One thing we've been very proud of is Store Outside Your Door, focusing on some of the traditional foods, hunt, fish, gather, grow. These are things that all Alaskans do, and encouraging people to eat healthy and also to be active.

We have colorectal cancer rates that are higher among Alaska Native people. So that's been a particular focus. You see Nolan, the colon, there with a nurse and some kids playing in there. It's a way for people to walk through a colon and to see some of the things that we look for with colonoscopy. I think the kids were saying something like, I have -- "I am the runs," as they went running through there. Yeah (affirmative), there's horrible puns that occur from Nolan.

You see some of our staff dressed up like polyps for the Fur Rhondy parade and good old Diana Redwood, actually uses her own body to teach colonic anatomy, love your colon. We also have some publications. This was actually a specific request of the Alaska Native Tribal Health Consortium Board. Two of them, and these are really oriented to reach the public. "We're all getting healthier," which are focused on health promotion, such as colorectal cancer screening, health indoor environments, oral health, and then also, what we call hot topics in Alaska Native health, and we've basically responded to requests from our communities, as well as from our providers.

For instance, we found that there was very little information out there about synthetic marijuana. So we did -- got as much information as we could, put that together and distributed it around the state. Of course, information includes things like press releases. We have the epidemiology bulletin, which is a long-standing and very well respected way to reach out to, particularly the health provider community, meetings and forums, such as just wrapped up -- the Hale Borealis forum is focused on hospital preparedness.

I threw this in just for grins. We actually, when I was -- Ward mentioned that I was at CDC. We actually had right there, as we're trying to do our work, "Good Morning America" broadcasting live from the emergency operation center in Alaska, but it was an important way to begin to continue to get the message out about what was going on with the pandemic and the response.

Essential function four, and this is where we start getting outside of some of the traditional ideas of public health, mobilizing community partnerships to identify and solve health problems. A couple of examples here, Recover Alaska is one that involves a number of our CEOs from around the state. It's focused on addressing challenges with alcohol abuse and addiction. United Way has 20 -- 90% by 2020, and that's focused on education, and I would want to point out again, that education level is one of those social

determinants that's been highly correlated with health outcomes.

We had, in Alaska, a remarkable combination of partners during the flu pandemic. You see Rachel Steer here having a ski-in to get her flu shot from Sue Ann Jenkerson (sp), and this was nearing the senior national trials and that was actually carried by satellite uplinked nationally.

Other coalitions, there's one with the American Hospital Association, CDC, a number of state health departments focusing on injection safety to reduce the risk of bloodborne pathogens, and I know our providers appreciate that because they would rather be proactive than reactive in addressing bloodborne pathogens.

I also wanted to mention coalitions of government agencies. This was a particular interest of mine. Post 9/11 and particularly, post anthrax, public health and law enforcement began to work together much more closely, and I know a number of places, including, at least for a while in Alaska, public health had a seat at the Joint Terrorism Task Force that is hosted by the FBI.

Five, develop policies and plans that support individual and community health efforts. That's part of all of you sitting around the table here. Earl Albrecht was our first territorial Health Commissioner. He worked with the American Medical Association to bring in a blue ribbon panel that

reviewed health status in Alaska that was published in J.A.M.A. 1947, and the led into the subsequent Perrin Report, which we celebrate the 60th anniversary of now, and this is part of what Healthy Alaskans 2020 is all about, is pulling people together around our community health efforts.

Plans and policies include things like all hazard mitigation, helping healthcare facilities develop tobacco free policies. Again, these are things that we do outside of government, often times, and I think the Tribal Health System, I'm looking at Lincoln, because I think of the Southeast Alaska Regional Health Consortium has been a real leader, in terms of going smoke-free in healthcare settings. It's a huge change. I remember, you know, working in the VA in the '80's, and always came home just literally reeking of smoke and my wife would always comment about that. That doesn't happen anymore.

University and most large organizations that are responsible for large numbers of people have pandemic flu plans now.

Sixth is enforce laws and regulations that protect health and ensure safety. This really is getting more into the governmental responsibilities, but it's really much broader than just inspection of swimming pools or restaurants. "Click it or ticket," is a good example. Also enforcement of tobacco control laws, and there is licensing. I threw in the

licensing for tattoo parlors. I don't understand tattoos myself. I still think of it as something that old people get. My kids think of it differently, but it's important that those -- for people that want to do that, that it's done safely.

Seven was one of those traditional public health functions. That's link people to needed personal health services and assure provision of healthcare when otherwise unavailable. The neighborhood health center and their beautiful new building is a great example of a safety net to healthcare. Tribal health often times serves that function of the safety net, also.

Also, some of the prevention services, ANTHC has been very focused on screening colonoscopy in partnership with a number of our regional corporations, including SEARHC, Maniilaq and Bristol Bay.

I wanted to also mention sort of where we have failed, at least nationally, in healthcare and public health, and that's identifying people who are infected with Hepatitis C and getting them into treatment, particularly now that we have medications that can achieve over 90% cure rates.

So far, we think that only about half of the people who have been infected with Hepatitis C have been diagnosed. I think what's most disturbing is this area here that we find that people who have been screened and found to have a history of infection, we know about 80% will be chronically infected.

Yet, it's only about half of those people who have ever been referred on for confirmatory testing.

We actually do better -- we have a good history of addressing viral hepatis in the Tribal Health System, but we continue to work to do better.

Number eight, assure a competent public and personal healthcare workforce. The Community Health Aide Program is a great example of that. It's been in place for a number of decades and we're actually in the process now of transforming that, really bringing it into the 21st century in terms of how we train our health aides, more of a focus on the didactic training, being computer-based, distance delivered and where as the time when the health aides are in Anchorage or in one of the regional hubs, that's when they get their clinical oversight and a time with a supervising physician or mid-level.

Community health aides are really all over the state. There's over 500 of them and they apply -- they provide about a quarter of a million patient encounters each year. The Dental Health Aide Therapist Program is an innovative program that basically provides basic -- trains people through a very intensive two-year program to provide basic dental services from the gumline up, because -- but because people are out in the villages, they're also -- you'll see a picture there, they learn how to take care of the equipment, because often times

they're doing the repairs themselves, and also a big focus on prevention.

Nine, evaluate effectiveness and accessability and quality of personal and population-based health services.

UNIDENTIFIED SPEAKER: (Indiscernible - too far from microphone) can't hear you.

DR. BUTLER: Okay, Hepatitis A is another great example, where we've had a vaccine program and through the surveillance, we've been able to evaluate the success of that and we almost see no Hepatitis A now. Whereas, we used to have huge outbreaks every year. I see Dr. Urata is smiling. I suspect he's done as I have, he's carried immune globulin either to an airplane or received it and spent a weekend pumping immune globulin into a lot of muscles back in the battle days.

Finally, research for new insights and innovative solutions to health problems. This one sort of surprised me, because at least in the assessment, we scored higher than national averages. We don't have a medical school. So we don't have a lot of clinical trials that occur here, not at least compared to places like Seattle.

Yet, for public health research, we have a remarkable array of resources between the Arctic Investigations Program here, the Tribal Health System, particularly ANTHC and Southcentral Foundation, and academic-based program, such as

the Center for Alaska Native Health Research at UAF.

I throw in just an example here, this is Karen Maiernyk, who has been an ANTHC employee that we've had detailed to the lab at CDC for more than a decade and maybe even two decades now. She hates this picture, but I included that because one of the projects that we did here in Alaska was evaluating the two types of pneumococcal vaccine and just a couple of weeks ago, the Advisory Committee on Immunization Practices came out with new guidelines for use of these vaccines. Of the 16 studies referenced, one of them was a study that came from Alaska. So we contribute, really, to the national policy, as well.

That was a whirlwind tour and I think I lost my bet with Dr. Hurlburt that I could do that in 20 minutes, but I'd be happy to take questions and also, I'd like to turn it over to Dr. Hurlburt to discuss how this fits into the ongoing assessment.

CHAIR HURLBURT: Are there any questions now? Lincoln, please.

COMMISSIONER BEAN: It comes with old age, we forget. I serve on the Alaska Tobacco Control Alliance. Does that recommendation come from this Commission or -- because I support it, because of what it does. It's not a good thing, smoking, cancer, heart -- all the stuff that goes on with tobacco, does that recommendation come from this Commission

for support?

CHAIR HURLBURT: We have recommended preventive efforts and including that -- maybe I should go ahead. I want to talk a little bit about public health here in Alaska and what we do, and I think it will get at that and so there may be other -- some other questions like that.

As Jay mentioned, there are 51 health departments, eight territorial health departments and if you've seen one, you've seen one. It is different in every state, in how they're organized. In Alaska, within the Division of Public Health, we have public health nursing, which is the biggest chunk and which would be pretty much normally within the health department.

We have epidemiology, which is kind of the basis of public health. Jay was the state epidemiologist for a while. Joe McLaughlin is now standing in the job there. We have chronic disease prevention and health promotion and that's where the smoking lies, and I'll come back to that in a little bit.

We have moved, where we die from infectious disease, although it's still a huge problem and immensely getting into the news right now, to where we die more and more of diseases of choice, through -- related to tobacco and obesity and lifestyle issues.

Then we have the labs. We have two labs here, really

nice labs. The one over on Tudor Road by ANMC there, where Martin Luther King Drive comes out, that does the bacteriology. It does some of the tox things, like if you expect dioxane, that's where it goes, and they look at that and then the newer, about six years old now, I guess, virology lab at UAF in Fairbanks.

We have the Women, Children, and Family Health, more commonly known as Maternal and Child Health, and they deal with issues related to women and child bearing and babies. This is where we've had some notable success. We are -- because of the challenges of the logistics of care and doing things in Alaska, we don't very often lead the nation. We lead the nation in having the lowest neonatal infant mortality rate. That's within the first 28 days of life.

In low birth weight infants, we have received awards from the March of Dimes for doing that, and this is not a flash in the pan. These are running three-year averages that we've done that for, and it reflects the work of a lot of people, of public health, clearly, Tribal Health System, where infant mortality rates, when I first started, were tragically high, a lot of grand multiparity means lots of babies for one mom and they have had an outstanding system that identifies high rate moms, high risk moms, rather, gets them into Anchorage where they can receive care.

The neonatal intensive care unit at Providence, the

neonatologists that are there, nurses and others have worked together for that achievement, and then there's some Bureau of Vital Statistics that does birth certificates, death certificates, marriage certificates, maintains the medical marijuana registry there. They operate there, the emergency preparedness that -- section.

The state medical examiner, that's the coroner's function and medical examiner's functions, so where there are deaths of undetermined causes, they decide whether or not a forensic autopsy should be done and determine that, and then the planning section. So that's how we're organized.

In most states, probably the environmental health programs are part of public health. Here, they are in the Department of Environment Health, although we collaborate together, communicate together well. That's organized there.

Within the Department of Health and Social Services, that used to be part of the Maternal and Child Health Program, which was kind of just split up when Governor Murkowski was in office there, but the WIC Program, the Women's, Infants, and Children, the food supplements there and so on, that is almost all state -- within public health. It's in another part of our department here, even Medicaid sometimes is. So each state is different.

Now, the Division of Public Health has identified five priority areas and it's kind of like our exercise this

morning, they're not the only things that are important, but over the last five years or so, we've had consistent five areas and I'll mention those.

The first is overweight and obesity, as the number one priority, and we picked this as the number one priority because the complications of overweight and obesity now, as I mentioned this morning, are costing the country's economy and the healthcare system more than anything else. It costs Alaska about half a billion dollars a year.

The rates of diabetes going up, when I first came to Alaska and was out in Dillingham, in two years, I never saw a patient at our hospital who had diabetes. There was one woman in town who's -- who's wife was non-Native, and at that time, she was not eligible to come to the IHS hospital, but she was half Native and half Anglo, and she did have diabetes, but there were -- other than that, there were no Native patients with diabetes, never saw a heart attack, myocardial infarction, in two years there and now, we're seeing more and more, and the rest of the country, even by then, diabetes was kind of the unique Indian pathology, but groups like the Pimas and the Papagos in the Southwest had become obese. The surgery ward at the Phoenix Indian Medical Center, which is the second largest Indian hospital in the country, none of them really hold a candle to ANMC here, in terms of what they can do and what the hospital is, but the Phoenix Indian

Medical Center, even then, the surgery ward was an amputation ward with people losing feet, losing legs, because of the diabetes.

So we -- that was not a problem when I came. One of the complications, as I mentioned this morning, a news item just this morning, that the -- one of the complications of obesity and overweight is cancer, certain types of cancer, breast cancer, for example, and that has now passed tobacco as a cause of cancer. Tobacco's still killing more people. So that's number one.

We've had programs like the one that I just passed out. We have focused, at the request of, actually one of the former liaisons for our department was in the Governor's Office and advised us, five years ago, focus on kids, first, not exclusively, but kids and that's really where the future is, but we have the Play Every Day Program, where we go into the schools. That's a private/public partnership. We, the Department of -- Division of Public Health has put in $125,000 a year, loss some money last year and we're probably about at 100 now, but basically, look where we could steal it and squeeze it and get the money to do that.

Providence Hospital puts in $100,000 a year, ConocoPhillips, 25, other businesses, smaller amounts, but we now have about 20% of the elementary school kids in the country, signing up twice a year for three months, spring

campaign and fall campaign, to commit to being physically active for at least half an hour, at least three days a week outside of the school hours and keeping a log, trying to get their parents involved, too, and then they get little prizes for completing their commitment there. So that's going.

We had about 2% of the kids five years ago participating and now, we're up running 20% and actually, the financial resources are kind of maxing us out on that. We've had other major successes.

The Anchorage School District, the Mat-Su School District have engaged in improving quality of school lunches, increasing physical activity in school, increasing recess activity and so, and we've actually seen a statistically significant small decline in the rates of obesity and overweight in the school kids, and have gotten some national attention for that, because we are seeing some flattening in rates of the increase in rates of obesity nationally among Americans, but that was good, and now, the Kenai Peninsula School District is also participating, which means we've got most of the kids in the state in that and we're wanting to get others.

The second priority is tobacco, which remains a huge problem. It's still the most lethal factor in causing premature death. The biggest challenge we have, are Alaska Native adults still, almost 40% smoke, just under 40%, but

dropping down two or three years ago, below 40% was a major step. It used to be much higher than that.

Historically, they didn't smoke. Again, my first two years here, we never saw anybody with lung cancer among the Native population. In the U.S. population, in general, if you saw a little, what we call a coin lesion a density on a chest x-ray, it was a lung cancer until proven otherwise. That wasn't the case among Alaska Natives, it was a granuloma, just like a TB or something like that, maybe a (indiscernible) coccus disease, until proven otherwise, and I can remember when we saw the first lung cancer.

Dr. Joe Wilson was at ANMC and Joe's words were, "It's coming," because Alaska Native men started smoking during the Second World War when Phillip Morris and all these other patriotic companies were passing out free cigarettes and they got hooked, and they came home and they got their spouses hooked and there had been -- by then, there had been -- by the '70's, enough pack-year history to start seeing it and so that remains the biggest challenge.

The smokeless forms of tobacco have continued to be a problem. They are addicting. You still see little kids, like particularly in Southwest Alaska with a little round circle on there back dungarees pocket. They're representative of Bob Herron from Bethel, former hospital administrator there has been a champion of trying to get more taxes, because

particularly, among the adolescents, the young people, taxes are an important anti-tobacco tool, and the history was interesting, where, you know, we tend to be a conservative state.

We tend to be a more Republican state and taxes are not a good word, but what Senator Con Bunde, who is retired from the Senate now, really saw that this is a health issue, much more than a tax issue, and when you could get a conservative senator like that onboard and to champion -- well, we have relatively high tobacco taxes now and a significant portion of that money goes for the anti-tobacco efforts, but it's had a big impact and we are now among the best states in adolescent smoking rates. Again, that's a huge success and that's a future and we have probably 10,000 Alaskans alive now that would not be alive if we had our former smoking rates, and I never can mention this without mentioning that the dedication of a portion of the tobacco settlement money, when the suits were brought, former Governor of -- Gregoire of Washington, who was the state Attorney General at the time, was the lead Attorney General, but a lot of states, including Alaska, participated and got these hundreds of billions of dollars of settlement from the tobacco companies for all the healthcare costs they had caused.

When Senator Sean Parnell was Chair of the Senate Finance Committee, he championed allocating a portion of that money

and a portion, relatively small portion, but a dedicated portion of the taxes for the anti-smoking efforts and so Alaska has been number one or number two among the states, related to our population, in our anti-smoking efforts and the succeeding governors and the succeeding members of the Legislature have continued to support that, but it was something that our current Governor deserves a lot of credit for, for taking on back in the '90's there.

The third emphasis, the third priority area is immunizations, and this is an area where we don't do very well. Five years ago, we were number 49 in the level of immunization among two-year-olds. We measure it at 19 to 35-months-old, and we've improved up to about number 36 or 37, so we've come up, but still not very good, which means a lot of kids are at risk.

Historically, the Tribal Health Program has done much better than the non -- for the non-Native population, the state's running about 90%. They have slipped down, for some reason. Some that's related to health records issues, but some of it's just the population is becoming more skeptical.

In Alaska, the place where we have the worst immunization rates of all for infants, for young children, like two-year-olds, is Talkeetna, and there's a lot -- I describe them as pony-tailed PhD's, but there are folks up there that are very bright. They're highly trained and they're too smart for

their own good, and they're denying immunizations to their kids, and the news just came out this week that one of the worst places in the country for immunization rates for kids is in Los Angeles, and not the Watts areas and not places like that, it's the very high rent, most affluent areas of Los Angeles because the parents are not wanting to let their kids be immunized.

Two quick stories on that here. In 1953, Ketchikan, which was much smaller than it is today, had 93 cases in 1953 of polio, 83 paralytic, and that was right when the save and vaccine was coming along. We were starting to get to vaccines. We did not get what we call parental hesitancy now when the public health nurses wanted to vaccinate the kids or the pediatricians or the docs did.

We had a mom who happened -- this was a provider story and I won't identify the source, but it happened to be, the mom was actually an injectable drug user, but who was not wanting to let her baby get immunized and didn't want them to get polio and the mom said, "What is polio?" So we've gone from 93 cases in one year in Ketchikan to moms now saying, "What is polio?"

We are now seeing a national outbreak of mumps, thousands of cases of mumps, and we've had the press calling and wanting to know, well, you know, what is mumps? What does it do? Why is it bad? One of the news reporters that called Dr. Michael

Cooper here at -- in our epidemiology section said, "What is mumps?" Now that's a huge success to go from what is was earlier in my career and even a young man like Jay's career, to say, "What is mumps," but it means we're now getting moms who are resisting and these diseases are still there. So that's our third priority.

The fourth is just as Jay mentioned, unintentional injury. Unintentional injury is still the leading cause of premature death among people from age one, once you get over that first year of age, from age one through age 44, so -- but as Jay mentioned, those -- the death rates have gone down. Alaska is high risk.

The way we play is high risk. The way we make our living is high risk. Commercial fishing is twice as risky as hard rock mining, as far as being a dangerous occupation to have. Logging, we -- our lives are high risk lives. It's wonderful to see a swimming pool open up in Bethel because drownings are -- we live on rivers. We commercially fish. We get out in the rivers with all the hot weather Bethel had this summer. You saw the picture in the papers. The kids out there played in the Kuskokwim. I bet it was still cold as ice, but they were playing in the water. Barrow, you know, when they started getting the money back in the mid '70's from the pipeline, they put a swimming pool in the high school there, and yeah (affirmative), that's good for recreation. It's good

for obesity, but it's also good for saving lives.

So unintentional injury remains a major focus and the last one, Representative Higgins raised the issue this morning, but it's fluoridation of public water supplies. As I mentioned, Anchorage, one of the earliest cities in the country, really to be proud of it, 1953, adopted it, and plenty of studies, some of the studies have been here in Alaska, a very recent one, the CDC did in Southwest Alaska looking at villages with fluoridated water and those that are not and the problem of dental caries and loss of teeth, much higher in the non-fluoridated villages and then with the high consumption of sugar-sweetened beverages here, where often in the villages a can of pop costs less than a bottle of water, and if you're living in one of the villages where you still don't have good water, they consume that.

So that's a battle that we're losing a little bit. We're going down. We lost Juneau. We lost Fairbanks. We lost Palmer. We -- there was an attack in Anchorage and we managed to prevail there. There was an attack in Bethel. Fortunately, the Mayor, Dr. Joe Klejka, who -- the Medical Director for YKHC, is the Mayor there and Gene Peltola, the recently retired CEO of YK said, "Ward," he said, "Don't worry about it. We'll take care it," and they did, so there, they had enough clout to keep that down in Bethel, but anyway, those are the five priorities that we've had.

We've done other things. These are just some neat posters that we have on overweight and obesity. It says, "A 20-ounce bottle of soda could have as much sugar as 16 chocolate mini doughnuts. You wouldn't eat that much sugar, so why drink it."

The -- it's a major challenge for the country. We can't -- I -- my own bias is the tobacco companies are really evil and that they knew tobacco was addicting and they still kept trying to push it. My -- I don't think that the -- those sugar companies, the Cokes and the Pepsis and the Dr. Peppers, I don't put them in the same class, and the reason why -- one of the reasons why is I met with their Government Affairs people from Coke, Pepsi, Dr. Pepper, and their bottlers and so on, and they were not in denial, and I said to them, "If you have to pick one thing that led to this epidemic of overweight and obesity, I would say it's sugar-sweetened beverages," but it's not the only thing. It's lifestyle issues. It's sitting in front of the screen. It's bigger portions. It's more affluence.

When I was little, if you got a six-ounce bottle of pop, you got it occasionally. It's a big treat. Now you get a 20-ounce bottle every day and drink more, and they were in agreement. So I think we can cooperate with the Cokes and with the McDonald's and those, whereas I don't think we ever could cooperate with the tobacco companies.

So we can learn a lot from tobacco for dealing with these issues, but I think we can partner with the people in business. I'll quit at that.

MS. ERICKSON: Thank you very much. Does anybody have any questions for Dr. Butler or Dr. Hurlburt? Yes, Becky.

COMMISSIONER HULTBERG: I have a question. I read an article a couple of months ago. It was really interesting. It talked about -- kind of dispelled the idea that the best public health strategy is to try to make sure there's a Whole Foods on every corner. I mean, there's not going to be, but for lack of a better analogy, and really said that one of the best public health things that could happen is if all of our fast food restaurants just incrementally lowered the number of calories per serving, and so it's kind of an obviously -- I just wondered from a public health standpoint, how would you react to that, because obviously, you have this balance between what's optimal and what's actually feasible.

CHAIR HURLBURT: Yeah (affirmative), servings have gotten bigger and that's a part of affluence. The food is easier to get. I think that there certainly is the concept of food deserts, where particularly in areas where less affluent people live, they just have a 7-Eleven or a convenient store.

On the other hand, to have a Whole Foods store where you go to get your arugula is probably not what we're going to see in a lot of places, but the concept of food deserts is real.

Some of the successes we've seen, for example, in the Snap Program, the food stamps program here, we had our folks that -- like Carol Fink, the nutritionist, work them, work with WIC, so that you could use food stamps at farmers' markets.

You didn't use to be able to do that, but they set up the logistics of being able to do that and I think there are efforts around the country trying to make more nutritious foods available. I think the issue is absolutely real.

Some of the larger grocery chains, I think have, you know, they want to do it to make money, but they have been sensitive to this issue of trying to go into underserved areas, so health diets can be purchased.

There is a perception that the healthy foods cost more. There was an interesting thing done in New York City where they asked, "Well, what would it cost to get kids in the school lunches to buy apples, instead of buying potato chips," and they wondered how much they would have to subsidize the apples and how much they would -- I mean, they would have to overcharge on the potato chips, and actually, they found out marketing could do it, that the potato chips and the Fritos had been out in nice attractive stands and were getting a lot of traffic and the apples and fruits were around back and they just changed that, and they kind of put the apples in your face, and it did reduce the amount that they were selling on the chips and increased the fruit there.

DR. BUTLER: If I could just add, I think one of the challenges with obesity that Dr. Hurlburt has addressed is that it's really a -- in many ways, a behavioral issue. When I think of public health, I think of sort of three eras, the 19th century, which was focused on sanitation, the improvement of living conditions, the availability of more pure foods, clean water, window screens in parts of the country where vector borne diseases were a major cause of morbidity and mortality. That began to bring down rates of disease, increase life expectancy.

During the 20th century, technology was the answer, primarily vaccines, drugs, water fluoridation, very simple technologies, but those were very successful. I mean, we eradicated an infection that used to affect more than half of the population and killed nearly a third of the people who became infected when we eradicated small pox.

I think sometimes we try to apply those technical fixes in the 21st century, where many of our challenges are going to be addressed more through other ways, such as behavior modification, and we try to find the magic bullet diet. People sell a lot of books and a lot of special foods.

You know, there's been a lot of studies that kind of boil down to, there's some minor differences, but a lot of it boils down to the calorie. I love the guy who -- I know this was self-experimentation, but he lived on nothing, but Twinkies

for three or four months and lost 20 pounds. His point was that he could control calories eating nothing, but Twinkies and still lose weight.

COMMISSIONER HIPPLER: So you brought up SNAP, which I would have some questions about. So given that obesity is a disproportionate problem among the low income people in our state, how would you suggest we modify that entitlement program to change food purchase patterns, I guess, if that's what's causing the obesity? How would you change that program to help?

CHAIR HURLBURT: That -- I think, you know, Jay mentioned substance determines the health and I think that's a part of the challenge there. There is more obesity among the less affluent people and a part of that is that they -- they're not able to get healthy foods as easily, but there are other parts of it also.

They may live in areas -- some of it's safety, that if you live in a neighborhood where if you're afraid your kids go out, they're going to get accosted by a drug dealer or get shot, which is the case in some neighborhoods, then you keep your kid inside and they don't get out and play.

We do have more people. You know, I think when I was growing up, kids could do things and your mom would tell you, "Don't do it," but you didn't get arrested, because kids do things, and it's harder now, particularly if you live in a

Harlem or a Watts, and I think that's a part of the issue.

The screen time, you know, then substitutes for it, the computer games, so but I -- so what about the SNAP? Well, I think, that you know, a small approach was, if you're going to have the program, then you -- if you can make healthy foods available, like in a farmers market, it's a good thing, but I think, you know, a part of the Republican answer, really, to that is, what can we do to help those people get jobs, to have them get an education to get a job to improve their life status, and historically, you know, that's been a strength of our country.

We've had a lot of mobility. People didn't just get stuck in the most affluent center or the least, and we seemed to have, in the last decade or two, seemed to have gotten more locked into that and so we, as a nation, and it doesn't mean my bias, it has to be a government situation and I don't know your bias, Allen, but that how can we have the folks that are on food stamps now, how can we give them the kinds of opportunities that in our mind, we think all Americans ought to have to be able to improve their status, to have a better life, so that they don't need to take advantage of that.

Certainly, if they're hungry, as a wealthy, compassionate country, we need to help people, but I don't know. That's kind of a complex answer. I don't -- I don't know of a simple answer to how to improve that

DR. BUTLER: I don't know if this is appropriate, but since you gave me a microphone. I agree with Dr. Hurlburt, although, I would add restricting the use of the SNAP card to exclude sweetened beverages would, I think be a great thing, something that public health agencies around the country have really been pushing for. The push back has come from USDA and the corn lobby.

COMMISSIONER BEAN: Medivaced last night, and this relative of mine, very obese, had a breast taken away about a month ago and she'd smoke a pack of cigarettes a day, and she was medivacked last night to here at ANMC because of pneumonia, and while she was laying in that bed, she said, "I wish I had a cigarette."

That's why I wanted to lean into that today, that you know, a lot of people in my family are big. All of the boys -- all of us are big, and believe it or not, I've lost 33 pounds in the past two months, and it's not easy when you carry this kind of weight. I can testify here, as a big guy, that once you put that weight on, it's very difficult -- it's not like you can do it just like that, but when I left here last night, I had to pick up another belt notch and I think -- it's starting to pay off, you know, but I wrap that cigarette story in with the cancer patient, I see E-cigarettes now cherry flavored for the kids. They're focusing on our children. I have a granddaughter that's two years old and she

loves fruit, and now we have cigarettes that are cherry flavored. Holy cow.

Now there's no conscious in an organization that will make it flavored for the children, and I agree with you that we support any kind of legislation supporting anything against tobacco use in our state, so that we could be a shining example for the other states. Thank you.

CHAIR HURLBURT: Yeah (affirmative), I think -- with electronic cigarettes now and the vaping shops and the flavorings being put in that, you know, the advocates are saying, well, it's a way to get -- to stop smoking, just like Nicorettes or nicotine patches, but I believe that it's more -- another gateway in, just like the Snus or the other smokeless tobaccos, and so we -- I think as a state, and it's new around the country.

The whole country is wrestling with the issue, but I think if we could have tobacco taxes on the various forms of tobacco, in addition to cigarettes, for example, the cigarillos, the little card cigars that are categorized as cigars, that look like a cigarette, I understand if you go to the Holiday or somewhere and maybe you'll get a bargain, get a pack of cigarettes for eight-and-a-half dollars and I'm told, the other may be two-and-a-half, because the taxes are so much lower.

So I think taxes are a part of that. The E-cigarette

issue is kind of non-controlled. The -- some people say, "Well, you can use them in places that are smoke-free." Generally, our definitions in Alaska are such that where we have smoke-free environments, like most of the population has, like Anchorage, for example, or Juneau, it will apply to electronic cigarettes, but it is a new challenge and one we have to be very sensitive to, and it could be that maybe we should be specific, as the Health Care Commission, to recommend to the Legislature the names of -- in terms of prevention a kind of -- as Senator Bunde adopted, but that taxes are a real health issue here and it particularly impacts young people and adolescents and so we should assure that we do as well as we've done with cigarettes with the other forms of tobacco.

DR. BUTLER: Could I just comment? We sometimes get a little uncomfortable when we start talking about redefining social norms, but I think tobacco is actually a great example of that. Nicotine is very addicting. We can see that. In the 19th century, Mark Twain said, "Quitting smoking was the easiest thing he's ever done." He did it 100 times. It is a very addictive substance, yet, rates are down and norms have changed.

I think most people around the table here are old enough to remember, even if you're family didn't smoke, what was on the coffee table. It was an ashtray and as we get into the

'60's, and people would visit, there was a bit of a change. Rather than just lining up, they would ask, "Do you mind if I smoke," and yet now, that question probably wouldn't be asked, not very common anyway.

Those ashtrays would not be there. Even people who smoke, generally smoke outside because they are aware of the dangers they pose to others through second-hand smoke. So it is an area where things change.

I guess this is the darker side of technology, new devices, such as E-cigarettes and without getting into Ballot Measure Two, I'll point out, that you know, there are other substances than nicotine that can be delivered through an E-cigarette.

COMMISSIONER URATA: I saw a couple of pieces of information, well, one piece of information. When we did the smoke-free campaign in Juneau a few years ago, the statistic that somebody gathered from the Cancer Society was if you increase the tobacco tax by one dollar, that would reduce a high school kid learning to smoke by 17% or something close to that. That might have been Murkowski's one dollar state tax on tobacco. It was way -- it was even further back than the Juneau Clean Air, and then the other thing is, I'm not sure if this is appropriate for this Commission, but I would pose the question, you know, should this Commission consider a recommendation for clean air to the Legislature?

As you know, the Heart Association, the Cancer Society, and the Lung Association, this past session worked hard to pass something and it may come up -- I'm pretty sure it's going to come up again, perhaps a better bill will come up in the next session, but that's something I think the Commission should consider.

UNIDENTIFIED SPEAKER: You and Deb (indiscernible - too far from microphone).

MS. ERICKSON: I didn't do it. I could talk about this all day and listen to it all day. Thank you very much, Dr. Butler, for coming and teaching us a little bit about public health and the essential services of public health, and again, I just want to reiterate that the assessment that was just completed was an assessment of how well the whole public health system, not just the state government piece, does at performing the 10 essential services of public health, and so you'll be seeing that shortly and keep that in mind, along with everything we've learned about what the Healthy Alaskans Initiative is doing around the 25 leading health indicators.

They'll be coming out with core strategies and action steps for improving each of those 10 leading health indicators sometime soon and since that is now one of our six, for prevention, general prevention, I would ask you to be thinking about what action steps you would want to take during meeting times and with our resources to advance the public health

questions.

We had some very specific suggestions here, but we'll follow up over email to see if we can come up with identifying those action steps.

We will move into our last agenda item of the day right now, and that is to see if you all have any additional changes. We've been working on these fraud and abuse findings and recommendations for a while now and have had leaders from the state programs involved with the Medicaid program integrity and with Medicaid fraud control, meet with us a couple of different times this year and that's brainstorming sessions we had and then refinement work over email is how we arrived at this current body.

I'm just explaining this for our two new -- our two newest members here, the current body of findings and recommendations we have. So we have this in draft. You all received it over the email a week or two ago, the latest draft, and I had actually sent a couple of different versions and you have them in your notebooks behind Tab 4.

One is dated 9/22, and it showed changes from our last meeting, and then I had been working with the Department of Law and had not heard back from them yet, and of course, minutes after I sent the -- sent to Jay and Jay got the response from the Department of Law, and so the more recent dated 9/24 with all the blue highlights showed the additional

changes that I made based on Department of Law feedback, and some of those were just comments, as well, but there is another 9/24 version that is clean.

I incorporated all of those changes, so you could read a clean copy, and I've got all of the findings and recommendations on slides right now, in case you want to propose any changes, we can see them.

What I'd like to do with the rest of our time today is see if we can incorporate any changes to this current draft that you all agree need to be made, and then at the end of our time today then, see if we can entertain a motion to approve, as draft for public comment, this set with any changes that you make just now, for release during November and then we'll consider, again, so you'll consider to have more time, if you want to work with your stakeholders separately, too, you'll have more time to do that and then we'll receive additional public comment before we actually finalize these, just to describe the process a little bit more. Yes.

COMMISSIONER URATA: Which version are we looking at now? Is this the one with the blue and yellow? Is that what you.....

MS. ERICKSON: You -- you could be looking at that. The date at the bottom is 9/24, but there's also a clean copy in front of that one that incorporates all the changes that those yellow and blue highlights show.

So I guess I'll just open it up. Maybe we'll just start with findings, first, so we're not jumping all around, and try to go in order. I'm not going to go through them each at a time, but of the findings, does anybody have any questions or comments or suggested changes?

CHAIR HURLBURT: These are changes before the document that goes out for public comment. So we'll get another shot at this in December?

UNIDENTIFIED SPEAKER: After public comments.

MS. ERICKSON: Right.

CHAIR HURLBURT: Yes.

MS. ERICKSON: Lincoln, and then Allen.

COMMISSIONER BEAN: Thank you. For the purposes of discussion I'd move for the recommendation of Fraud and Abuse Findings and -- with these recommendations, that would be my motion, and then we can pose it under discussion.

COMMISSIONER URATA: Second.

MS. ERICKSON: Very good, thank you.

CHAIR HURLBURT: Allen, did you have some discussion on this, moved and seconded?

COMMISSIONER HIPPLER: Yes, Item 9, we're talking about recipients have no financial incentives, I think we mean beneficiaries. Could you verify what word we mean as recipients have no financial incentives?

MS. ERICKSON: Is it eight?

COMMISSIONER HIPPLER: Number nine, ma'am, the first bullet point.

MS. ERICKSON: So the first bullet, recipients have no financial incentives to provide a check on potential fraudulent practices and also don't receive an explanation of benefits statement. So you had a question about that?

CHAIR HURLBURT: The suggestion was, so that beneficiaries is a clearer word than recipients. Recipients means recipients of services, but.....

COMMISSIONER URATA: They're the same as beneficiaries of services.

CHAIR HURLBURT: I didn't hear what you said, Bob.

COMMISSIONER URATA: Beneficiaries and recipients are the same people. So which is a clearer statement, word, beneficiaries or recipients of service?

COMMISSIONER HIPPLER: This is where having a laymen on the Board is useful. I can tell you that recipient is confusing to people who do not have this kind of medical background, because they think the person who's receiving the money, which is the medical care provider.

MS. ERICKSON: So would it be more clear if I changed the word recipient to Medicaid beneficiary?

COMMISSIONER HIPPLER: Or patient or whatever.

CHAIR HURLBURT: Yeah (affirmative), I see (indiscernible - too far from microphone).

MS. ERICKSON: This was specific to the Medicaid, this particular finding is specific to the Medicaid program, I think. Yes.

COMMISSIONER MORGAN: Before Lincoln pushes his button, I think what you're saying was good, just replacing recipient beneficiary, in the tribal system, we have beneficiaries that qualify for tribal benefits. So if you're going to take out recipient and make it beneficiary, I think adding the word Medicaid, as you suggested is better.

The common usage in the tribal system is beneficiaries or non-beneficiaries that are eligible to receive tribal health benefits. So you can -- I think what you said is the way to do it, if you're going to take out recipient, but recipients, usually the common technical term in reimbursement.

MS. ERICKSON: Right.

COMMISSIONER MORGAN: But changing it's not a problem.

MS. ERICKSON: And as far as process, we -- as we make these changes, at least at this process -- point in the process when we're still -- if something's not controversial and we're still just finalizing it as draft, we don't get too formal in making these changes. We just kind of look around the table for consensus. So does anybody disagree with changing the word recipient to Medicaid beneficiaries? Okay, other questions, comments, suggestions for improvement? Yes, Allen.

COMMISSIONER HIPPLER: So I'm thinking of the discussion we had about fraud in Medicaid and one of the things that sticks out in my mind is that we have certain medical care professionals who are otherwise very honorable people, who feel like they're being cheated by Medicaid.

So why not even the tables by double-billing, so they actually get paid appropriately, and in their mind, it somehow justifies this fraud. That's one of -- part of the discussion that stuck out with me, and I don't know how to put that in here, but there's this -- there's sort of this danger of people being able to look at themselves in the mirror and justify their actions on this, as far as fraud. So I just thought I'd bring that up. I don't know how to put that in writing, but it's something that's really stuck with me ever since then and I've thought about it quite a bit.

CHAIR HURLBURT: But probably, that's less germane in Alaska than in 49 other states. You know, it is a sense of fairness, in which an individual may rationalize unacceptable practices, but less so here, where Medicaid reimbursement is significantly higher than Medicare, lower than commercial, but about two-and-a-half times what it is in Washington State, overall. Bob.

COMMISSIONER URATA: I also think the option the provider might have is to not accept Medicaid patients, so -- and in my own experience, I have not seen what you mentioned could

happen and what I have seen, though, is that people don't accept Medicaid.

CHAIR HURLBURT: I have seen stories of that in other parts of the country and I was -- my own bias was especially primary care docs in Washington state and it was a state fee schedule that they were paid, but they had to be very community oriented and altruistic to accept that, and they did. The vast majority of the ones that were acceptable to us and credential process accepted it. It was one of the idealistic things about the docs. They were doing that for their community, but the fees were insultingly low there, but I didn't see that among the primary care docs there.

COMMISSIONER MORGAN: I think when you -- as I remember the discussion, every profession has a few crooks, I mean, you now, we're human -- they're human beings. We're human beings, not demigods and you always have the one.....

UNIDENTIFIED SPEAKER: Except medical (indiscernible - too fra from microphone).

COMMISSIONER MORGAN: Yeah (affirmative), that's true, except for the economists, but the -- there's a few bad apples and picked the profession, but some -- I've worked and even did a couple of summer interns as a Medicaid auditor in Kentucky and talking to professional staff there that have worked in Florida and places like that, we have no concept of what real fraud is with Medicare bills. Alaska's very small.

Yeah (affirmative), every once in a while, they'll be the obscure dentist or the home health agency or the people doing travel or PCA, which has been most of them lately, of real fraud, you know, where you arrest people, but I can tell you, with Medicaid and Medicare, they try -- if you screw up, they try three or four -- they try at least times to try to get you to correct what you're doing, pay back the money, and we'll all be -- we'll all -- we'll just watch you for a while and we'll all be nice.

Real crooks, the very few that we have, or even -- are just far and few between, and I think the last ones, as I remember, were -- was home health, some travel, and a PCA, wasn't it? I don't think we've had a lot of physicians, dentists, psychiatrists, who are really defrauding, you know, you know what I'm getting at, a Medicare mil kind of stuff.

MS. ERICKSON: So if there aren't any other suggestions for making any improvements to the findings statements, is there any questions, comments, or suggestions for the recommendations?

COMMISSIONER BEAN: Call for the question.

CHAIR HURLBURT: The question's been moved and -- the questions been moved and seconded and called. All those in favor say, "Aye."

ALL: Aye.

CHAIR HURLBURT: Opposed, the same. The motion carries.

Thank you, Lincoln.

MS. ERICKSON: I think we are done for the day. Thank you all very much for your time. I know it's been a really long day, but we did some good work today, and we have some excellent presentations, I think, scheduled for tomorrow morning on clinical quality improvement, we're really looking forward to, and then we'll have Commissioner Streur and I think Lori is coming back, too, to update us on the Medicaid Reform Advisory Group and any other questions we might have related to the Affordable Care Act implementation. I think -- I would not leave anything of value, but -- which means you could leave your meeting notebook, but we have the room overnight, don't we, Barb, yeah (affirmative). Thank you.

CHAIR HURLBURT: Thank you.

4:39:33

(Off record)

SESSION RECESSED